DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

BUREAU OF WORKERS' DISABILITY COMPENSATION

WORKER'S COMPENSATION HEALTH CARE

PART 1. GENERAL PROVISIONS

R 418.10101 Scope.
Rule 101. (1) These rules do all of the following:
(a) Establish procedures by which the employer shall furnish, or cause to be furnished, to an employee who receives a personal injury arising out of and in the course of employment, reasonable medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal, when needed. The employer shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably possible, and relieve from the effects of the injury.
(b) Establish schedules of maximum fees by a health facility or health care provider for such treatment or attendance, service, device, apparatus, or medicine.
(c) Establish procedures by which a health care provider shall be paid.
(d) Provide for the identification of utilization of health care and health services above the usual range of utilization for such services, based on medically accepted standards, and provide for acquiring by a carrier and by the workers' compensation agency the necessary records, medical bills, and other information concerning any health care or health service under review.
(e) Establish a system for the evaluation by a carrier of the appropriateness in terms of both the level of and the quality of health care and health services provided to injured employees, based upon medically accepted standards.
(f) Authorize carriers to withhold payment from, or recover payment from, health facilities or health care providers, which have made excessive charges or which have required unjustified treatment, hospitalization, or visits.
(g) Provide for the review by the workers' compensation agency of the records and medical bills of any health facility or health care provider which have been determined by a carrier not to be in compliance with the schedule of charges established by these rules or to be requiring unjustified treatment, hospitalization, or office visits.
(h) Provide for the certification by the workers' compensation agency of the carrier's professional utilization review program.
(i) Establish that when a health care facility or health care provider provides health care or health care service that is not usually associated with, is longer in duration than, is more frequent than, or extends over a greater number of days than that health care or service usually does with the diagnosis or condition for which the patient is being treated, the health facility or health care provider may be required by the carrier to explain the necessity in writing.
(j) Provide for the interaction of the workers' compensation agency and the department of labor and economic growth for the utilization of departmental procedures for the resolution of workers' compensation disputes.
(k) Are intended for the implementation and enforcement of section 315(2) to (9) of the act, provide for the implementation of the workers' compensation agency's review and decision responsibility vested in it by those statutory provisions. The rules and definitions are not intended to supersede or modify the workers' disability compensation act, the administrative rules of practice of the workers' compensation agency, or court decisions interpreting the act or the workers' compensation agency's administrative rules.
(2) An independent medical examination shall be exempt from these rules and may be requested by a carrier or an employee. An independent medical examination, (IME), shall be conducted by a practitioner other than the treating practitioner. Reimbursement for the independent medical evaluation shall be based on a contractual agreement between the provider of the independent medical evaluation and the party requesting the examination.
(3) These rules and the fee schedule shall not pertain to health care services which are rendered by an employer to its employee in an employer-owned and employer-operated clinic.
(4) If a carrier and a provider have a contractual agreement designed to reduce the cost of workers' compensation health care services below what would be the aggregate amount if the fee schedule were applicable, the contractual agreement shall be exempt from the fee schedule. The carrier shall be required to do both of the following:
(a) Perform technical and professional review procedures.
(b) Provide the annual medical payment report to the health care services division of the workers' compensation agency.
History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10102
Source: 1998-2000 AACS.

R 418.10103 Complaints.
Rule 103. Any person who is affected by these rules may submit a written complaint to the workers' compensation agency regarding the actions of any other person who is affected by these rules.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10104 Reimbursement to injured worker or to health insurer for compensable medical services.
Rule 104. (1) Notwithstanding any other provision of these rules, if an injured worker has paid for a health care service and at a later date a carrier is determined to be responsible for the payment, then the injured worker shall be fully reimbursed by the carrier.
(2) The injured worker may submit the request for reimbursement on a medical or dental claim form, but shall supply to the carrier a copy of a statement including the provider name, the date of service, the procedure and diagnosis and documentation of the amount paid.
(3) When a health insurer pays for a medical service to treat an injured worker and subsequently requests reimbursement from the workers' compensation carrier, the health insurer is not required to submit the request on a CMS 1500, or a UB-92 claim form, or other medical or dental claim form. The health insurer shall supply to the workers' compensation carrier, or the carrier's designee, a claim detail showing the date of service, the amount billed and paid, the procedure code and diagnosis for the rendered services. The workers' compensation carrier shall reimburse the health insurer the provider's usual and customary fee or the maximum allowable fee, whichever is less, for the compensable medical services in accordance with these rules. If the health insurer reimbursed the provider less than the amount allowed by these rules, then the workers' compensation carrier shall reimburse the amount paid by the health insurer.
History: 2000 MR 6, Eff. May 11, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10105
Source: 2003 AACS.

R 418.10106
Source: 2004 AACS.

R 418.10107 Source documents; adoption by reference.
Rule 107. The following documents are adopted by reference in these rules and are available for inspection at, or purchase from, the workers' compensation agency, health care services division, P.O. Box 30016, Lansing, Michigan 48909, at the costs listed or from the organizations listed:
(a) "Physicians' Current Procedural Terminology (CPT®) 2005," standard edition, copyright October 2004, published by the American Medical Association, PO Box 930876, Atlanta GA, 31193-0876, order # OP054105CFJ ISBN: 1-57947-578-7, 1-800-621-8335. The publication may be purchased at a cost of $62.95, plus $9.95 for shipping and handling as of the time of adoption of these rules. Permission to use this publication is on file in the workers' compensation agency.
(b) "Medicare's National Level II Codes, HCPCS, 2005," copyright November 2004, published by the American Medical Association, P.O. Box 930876 Atlanta GA 31193-0876, order # OP095105CFJ ISBN: 1-57947-571-X, customer service 1-800-621-8335. The publication may be purchased at a cost of $89.95, plus $11.95 for shipping and handling as of the time of adoption of these rules.
(c) "Medicare RBRVS 2004: The Physicians' Guide," published by the American Medical Association, 515 North State Street, Chicago IL, 60610, 1-800-621-8335. The publication may be purchased at a cost of $79.95, plus $11.95 shipping and handling as of the time of adoption of these rules.
(d) "Medicare RBRVS 2005: The Physicians' Guide," published by The American Medical Association, 515 North State Street, Chicago Il, 60610, order #OPO59605CFJ, 1-800-621-8335. The publication may be purchased at a cost of $84.95, plus $11.95 shipping and handling as of the time of adoption of these rules.
(e) "International Classification of Diseases, ICD-9-CM 2005 Volumes 1 & 2" copyright 2004, American Medical Association, P.O. Box 930876, Atlanta GA 31193-0876, order #OP068105CFJ, 1-800-621-8335. The publication may be purchased at a cost of $64.95, plus $9.95 shipping and handling as of the time of adoption of these rules.
(f) "2004 Drug Topics Red Book," published by Medical Economics Company Inc., Five Paragon Drive, Montvale, NJ 07645-1742, 1-800-678-5689. The publication may be purchased at a cost of $75.95, plus $9.95 for shipping and handling as of the time of adoption of these rules.
(g) "Michigan Uniform Billing Manual," developed in cooperation with the American Hospital Association's National Uniform Billing Committee, published by Michigan Health and Hospital Association, Attn: UB-92 Subscriptions, 6215 West St. Joseph Highway, Lansing, MI 48917, 517-886-8366. As of the time of adoption of these rules, the cost of the publication

is $160.00, plus 6% sales tax.
History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar.4, 2003; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10108 Definitions; A to I.
Rule 108. As used in these rules:
(a) "Act" means 1969 PA 317, MCL 418.101 et seq.
(b) "Adjust" means that a carrier or a carrier's agent reduces a health care provider's request for payment to the maximum fee allowed by these rules, to a provider's usual and customary charge, or, when the maximum fee is by report, to a reasonable amount. Adjust also means when a carrier re-codes a procedure, or reduces payment as a result of professional review.
(c) "Agency" means the workers' compensation agency in the department of labor & economic growth.
(d) "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place.
(e) "BR" or "by report" means that the procedure is not assigned a relative value unit, (RVU) or a maximum fee and requires a written description.
(f) "Carrier" means an organization which transacts the business of workers' compensation insurance in Michigan and which may be any of the following:
(i) A private insurer.
(ii) A self-insurer.
(iii) One of the funds of chapter 5 of the act.
(g) "Case" means a covered injury or illness which occurs on a specific date and which is identified by the worker's name and date of injury or illness.
(h) "Case record" means the complete health care record which is maintained by a carrier and which pertains to a covered injury or illness that occurs on a specific date.
(i) "Complete procedure" means a procedure that contains a series of steps that are not to be billed separately.
(j) "Covered injury or illness" means an injury or illness for which treatment is mandated by section 315 of the act.
(k) "Current procedural terminology", (CPT)" means a listing of descriptive terms and identifying codes and provides a uniform nationally accepted nomenclature for reporting medical services and procedures. "Current procedural terminology" provides instructions for coding and claims processing.
(l) "Dispute" means a disagreement between a carrier or a carrier's agent and a health care provider on the application of these rules.
(m) "Durable medical equipment" means specialized equipment which is designed to stand repeated use, which is used to serve a medical purpose, and which is appropriate for home use.
(n) "Emergency condition" means that a delay in treating a patient would lead to a significant increase in the threat to the patient's life or to a body part.
(o) "Established patient" means a patient whose medical and administrative records for a particular covered injury or illness are available to the provider.
(p) "Expendable medical supply" means a disposable article that is needed in quantity on a daily or monthly basis.
(q) "Facility" means an entity licensed by the state in accord with 1978 PA 368, MCL 333.1101 et seq. The office of an individual practitioner is not considered a facility.
(r) "Focused review" means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.
(s) "Follow-up days" means the days of care following a surgical procedure that are included in the procedure's maximum allowable payment, but does not include care for complications. If the surgical procedure lists "xxx" for the follow-up days, then the global concept does not apply. If "yyy" is listed for follow-up days, then the carrier shall set the global period. If "zzz" is used, then the procedure code is part of another service and falls within the global period of the other service.
(t) "Health care organization" means a group of practitioners or individuals joined together to provide health care services and includes any of the following:
(i) Health maintenance organization.
(ii) Industrial or other clinic.
(iii) Occupational health care center.
(iv) Home health agency.
(v) Visiting nurse association.
(vi) Laboratory.
(vii) Medical supply company.
(viii) Community mental health board.
(u) "Health care review" means the review of a health care case or bill, or both, by a carrier, and includes technical health

care review and professional health care review.
(v) "Incidental surgery" means a surgery which is performed through the same incision, on the same day, by the same doctor of dental surgery, doctor of medicine, doctor of osteopathy, or doctor of podiatry and which is not related to diagnosis.
(w) "Independent medical examination" means an examination and evaluation which is requested by a carrier or an employee and which is conducted by a different practitioner than the practitioner who provides care.
(x) "Independent procedure" means a procedure that may be carried out by itself, separate and apart from the total service that usually accompanies it.
(y) "Industrial medicine clinic" also referred to as an "occupational health clinic" means an organization that primarily treats injured workers. The industrial medicine clinic or occupational clinic may be a health care organization as defined by these rules or may be a clinic owned and operated by a hospital for the purposes of treating injured workers.
(z) "Insured employer" means an employer who purchases workers' compensation insurance from an insurance company that is licensed to write insurance in the state of Michigan.
History: 2000 MR 6, Eff. May 11, 2000; 2001 MR 8, Eff. May 9, 2001; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10109 Definitions; M to U.
Rule 109. As used in these rules:
(a) "Maximum allowable payment" means the maximum fee for a procedure that is established by these rules, a reasonable amount for a "by report" procedure, or a provider's usual and customary charge, whichever is less.
(b) "Medical only case" means a case that does not involve wage loss compensation.
(c) "Medical rehabilitation" means, to the extent possible, the interruption, control, correction, or amelioration of a medical or a physical problem that causes incapacity through the use of appropriate treatment disciplines and modalities that are designed to achieve the highest possible level of post-injury function and a return to gainful employment.
(d) "Medically accepted standards" means a measure which is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services ensuring that the health care is suitable for a particular person, condition, occasion, or place.
(e) "Morbidity" means the extent of illness, injury, or disability.
(f) "Mortality" means the likelihood of death.
(g) "New patient" means a patient who is new to the provider for a particular covered injury or illness and who needs to have medical and administrative records established.
(h) "Nursing home" means a nursing care facility, including a county medical care facility, created pursuant to the provisions of 1885 PA 152**,** MCL 36.1 et seq.
(i) "Orthotic equipment" means an orthopedic apparatus that is designed to support, align, prevent or correct deformities of, or improve the function of, a movable body part.
(j) "Pharmacy" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.
(k) "Practitioner" means an individual who is licensed, registered, or certified as used in the Michigan public health code, 1978 PA 368, MCL 333.1101 et seq.
(l) "Primary procedure" means the therapeutic procedure that is most closely related to the principal diagnosis.
(m) "Properly submitted bill" means a request by a provider for payment of health care services which is submitted to a carrier on the appropriate completed claim form with attachments as required by these rules.
(n) "Prosthesis" means an artificial substitute for a missing body part. A prosthesis is constructed by a "prosthetist", a person who is skilled in the construction and application of a prosthesis.
(o) "Provider" means a facility, health care organization, or a practitioner.
(p) "Reasonable amount" means a payment based upon the amount generally paid in the state for a particular procedure code using data available from the provider, the carrier, or the workers' compensation agency, health care services division.
(q) "Restorative" means that the patient's function will demonstrate measurable improvement in a reasonable and generally predictable period of time and includes appropriate periodic care to maintain the level of function.
(r) "Secondary procedure" means a surgical procedure which is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and which is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition.
(s) "Specialist" means any of the following entities that are board-certified, board-eligible, or otherwise considered an expert in a particular field of health care by virtue of education, training, and experience generally accepted in that particular field:
(i) A doctor of chiropractic.
(ii) A doctor of dental surgery.
(iii) A doctor of medicine.

(iv) A doctor of optometry.
(v) A doctor of osteopathic medicine and surgery.
(vi) A doctor of podiatric medicine and surgery.
(t) "Subrogation" means substituting one creditor for another. An example of subrogation in workers' compensation is when a case is determined to be workers' compensation and the health benefits plan has already paid for the service and is requesting the workers' compensation carrier or the provider to refund the money that the plan paid on behalf of the worker.
(u) "Technical surgical assist" means that additional payment for an assistant surgeon, referenced in R 418.10416 of these rules, is allowed for certain designated surgical procedures. The Health Care Services Manual, published annually by the workers' compensation agency, denotes a surgical procedure allowing payment for the technical surgical assist with the letter "T."
(v) "Treatment plan" means a plan of care for restorative physical treatment services that indicates the diagnosis and anticipated goals.
(w) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges which were previously billed separately and which are included in the package for that procedure as defined by these rules. A usual and customary charge for a procedure shall be calculated based on data beginning January 1, 2000.
History: 2000 MR 6, Eff. May 11, 2000; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10110 Program Information.
Rule 110. The workers' compensation agency shall provide ongoing information regarding these rules for providers, carriers, and employees. The program shall include distribution of appropriate information materials. The health care services division shall provide periodic informational sessions for providers, billing organizations, and carriers.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10111 Advisory committee.
Rule 111. The director of the workers' compensation agency shall appoint an advisory committee from names solicited from provider, carrier, and employee organizations. The advisory committee shall include five advocates for the concerns of providers, five advocates for the concerns of employees, and five advocates for the concerns of carriers. The director of the workers' compensation agency shall appoint a sixteenth member to act as chair without a vote. The advisory committee shall meet not less than twice a year. Additional meetings shall be scheduled if requested by the workers' compensation agency, the chair, or a majority of the committee. Members may be removed by the director of the workers' compensation agency for cause or for missing more than one-half of the meetings in a year. The advisory committee shall perform general program oversight and assist the workers' compensation agency with the following:
(a) Annual review of the rules and the fee schedule.
(b) Development of proposed amendments to the rules and fee schedule, including payment methodologies.
(c) Review of data reports and data analyses.
(d) Review health care service disputes, resulting from a carrier's professional health care review program pursuant to these rules, that are considered by mediation, arbitration, small claims, or magistrate decisions, based on annual summary data regarding such disputes. This summary data shall be developed by the agency and shall include information regarding carriers and providers which accounts for a significant number of disputes.
(e) Review annual summary data of complaints made to the workers' compensation agency.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10112
Source: 1998-2000 AACS.

R 418.10113
Source: 1998-2000 AACS.

R 418.10114
Source: 1998-2000 AACS.

R 418.10115 Responsibilities of insured employer or self-insurer.
Rule 115. (1) An insured employer shall do all of the following:
(a) Promptly file form 100, employer's basic report of injury, to report an injury that results in 7 or more days of disability, specific loss, or death, with the workers' compensation agency and its insurer.

(b) Promptly notify its insurer of the cases that do not result in 7 or more days of disability, specific loss, or death.
(c) Promptly inform the provider of the name and address of its insurer or the designated agent of the insurer to whom health care bills should be sent.
(d) If an insured employer receives a bill, then the insured employer shall promptly transmit the provider's bill and documentation to the insurer or the designated agent of the insurer regarding a related injury or illness.
(2) For the purposes of this rule, a self-insurer shall promptly report all employee work-related injuries to their designated agent, unless they are self-administered.
(a) Unless self-administered, a self-insurer receiving a bill for a medical service shall forward the bill to their designated agent for processing and shall inform the medical provider of the address where future bills shall be sent.
History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10116
Source: 2003 AACS.

R 418.10117 Carrier responsibilities.
Rule 117. (1) The carrier or its designated agent shall assure that a billing form is completed properly before making payment to the licensed provider or licensed facility.
(2) A carrier may designate a third party to receive provider bills on its behalf. If a carrier instructs the provider to send the medical bills directly to the third party, then the 30-day limit of this rule begins when the third party receives the bill. The carrier is responsible for forwarding bills and medical documentation when there is a third party reviewing medical bills for the carrier.
(3) A carrier or designated agent shall make payment of an unadjusted and properly submitted bill within 30 days of receipt of a properly submitted bill or shall add a self-assessed 3% late penalty to the maximum allowable payment as required by these rules.
(4) A carrier or designated agent shall record payment decisions on a form entitled "The Carrier's Explanation of Benefits" using a format approved by the workers' compensation agency. The carrier or designated agent shall keep a copy of the explanation of benefits and shall send a copy to the provider and to the injured worker. The carrier's explanation of benefits shall list a clear reason for the payment adjustment or amount disputed and shall notify the provider what information is required for additional payment.
(5) A carrier or designated agent shall make payment of an adjusted bill or portion of an adjusted bill within 30 days of receipt of the properly submitted bill. If a carrier or designated agent rejects a bill in its entirety, then the carrier or designated agent shall notify the provider of the rejection within 30 days after receipt of a properly submitted bill.
(6) If a carrier requests the provider to send duplicated copies of the documentation required in part 9 or additional medical records not required by these rules, then the carrier shall reimburse the provider for the copying charges in accord with R 418.10118.
(7) When the carrier has disputed a case and has not issued a copy of the formal notice of dispute to the medical provider, then the carrier's explanation of benefits shall be sent in response to the provider's initial bill. The carriers' explanation of benefits shall serve as notice to the provider that non-payment of the bill is due to the dispute.
History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb.10 2005.

R 418.10118 Practitioner, facility, and health care organization copying charge for medical records.
Rule 118. (1) A practitioner, facility, or health care organization shall, at the request of the carrier, the carrier's agent, the employee, or the employee's agent, furnish copies of the case record for a particular covered injury or illness to the carrier, the carrier's agent, the employee, or the employee's agent. The maximum fee for providing copies shall be 45 cents per page, plus the actual cost of mailing. In addition, an administration charge for the staff's time to retrieve and copy the records shall be paid as follows:

0-15 minutes	$2.50
Each additional 15 minute increment	$2.50

The copying and handling charge shall apply to all reports and records, other than the original copy required pursuant to the provisions of R 418.10113, and all other reports required by these rules. The party who requests the records shall pay the copying charge.
(2) The copying charge for each x-ray film requested by the carrier or the carrier's agent shall be reimbursed at $15.00, which includes mailing and handling.
(3) If an agent of a carrier or an employee requests a copy of the case record, then the agent shall indicate the date of injury.

Only the records for a specific date of injury covered by the act and these rules are available as specified in subrule (1) of this rule.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10119
Source: 1998-2000 AACS.

R 418.10120 Recovery of payment.
Rule 120. (1) Nothing in this rule shall preclude the recovery of payment for services and bills which may later be found to have been medically inappropriate or paid at an amount that is more than the maximum allowable payment.
(2) If the carrier makes a request to the provider for the recovery of a payment within 1 year of the date of payment and includes a statement of the reasons for the request, then the carrier may recover a payment. The carrier may recover a payment made by an employee or the carrier.
(3) Within 30 days of receipt of the carrier's request for recovery of the payment, the provider shall do either of the following:
(a) If the provider is in agreement with the request, then the provider shall refund the payment to the carrier.
(b) If the provider is not in agreement with the request, then the provider shall supply the carrier with a written detailed statement of the reasons for its disagreement, together with a refund of the portion, if any, of the payment that the provider agrees should be refunded.
(4) If the carrier does not accept the reason for disagreement supplied by the provider, then the carrier may file an application for mediation or hearing as provided for in R 418.101303 and R 418.101304. Within 30 days of receipt of the provider's statement of disagreement, the carrier shall file the application for mediation or hearing with the workers' compensation agency and the carrier shall mail a copy to the provider.
(5) If, within 60 days of the carrier's request for recovery of a payment, the carrier does not receive either a full refund of the payment or a statement of disagreement, then, at the option of the carrier, the carrier may do either or both of the following:
(a) File an application for mediation or hearing and mail a copy to the provider.
(b) Reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment.
(6) If, within 30 days of a final order of a magistrate, the appellate commission, or the courts, a provider does not pay in full any refund ordered, then the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10121
Source: 2003 AACS.

PART 2. MEDICINE

R 418.10201
Source: 1998-2000 AACS.

R 418.10202
Source: 2004 AACS.

R 418.10203
Source: 1998-2000 AACS.

R 418.10204
Source: 1998-2000 AACS.

R 418.10205
Source: 2002 AACS.

R 418.10206
Source: 1998-2000 AACS.

R 418.10207
Source: 2001 AACS.

R 418.10208
Source: 1998-2000 AACS.

R 418.10209
Source: 1998-2000 AACS.

R 418.10212
Source: 1998-2000 AACS.

R 418.10213
Source: 1998-2000 AACS.

R 418.10214
Source: 2004 AACS.

PART 4. SURGERY

R 418.10401
Source: 1998-2000 AACS.

R 418.10403
Source: 1998-2000 AACS.

R 418.10404 Follow-up care occurring during global service.
Rule 404. (1) Follow-up care for a diagnostic procedure shall refer only to the days required to recover from the diagnostic procedure and not the treatment of the underlying condition.
(2) Follow-up care for therapeutic surgical procedures includes only that care which is usually part of the surgical service. Complications, exacerbations, recurrence, or the presence of other compensable diseases or injuries requiring additional services should be reported with the identification of appropriate procedures. The follow-up days for the surgical procedures are adopted from the "Medicare RBRVS The Physicians Guide" as referenced in R 418.10107(d). The follow-up days for each surgical procedure are identified in the "global" column in the manual published by the workers' compensation agency separate from these rules.
(a) If a carrier requests the surgeon to see an injured worker during the global service period for the purpose of job restrictions, job adjustments, or return to work, then the visit shall not be considered part of the global surgery package. If the carrier requests the visit, then the carrier shall prior authorize the visit assigning an authorization number. The provider shall bill the visit using procedure 99455 and modifier –32, including the authorization number in box 23 of the CMS 1500 form. The carrier shall not deny a prior authorized visit and shall reimburse the provider for the prior authorized visit. The maximum allowable payment for 99455-32 shall be listed in rule R 418.101502.
(b) The medical record shall reflect job adjustments, job restrictions or limitations, or return to work date and the provider shall include the medical record with the bill.
(c) If an insured employer requests the surgeon to see an injured worker during the global surgery period for the purpose of job adjustments, restrictions, or return to work, then the employer shall obtain the prior authorization number from the carrier for the visit.
(3) Hospital follow-up care or a hospital visit by the practitioner responsible for the surgery shall be considered part of the surgical follow-up days listed for the procedure and shall not be paid as an independent procedure.
History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10405
Source: 2002 AACS.

R 418.10406
Source: 2002 AACS.

R 418.10407
Source: 2002 AACS.

R 418.10410
Source: 1998-2000 AACS.

R 418.10411
Source: 2002 AACS.

R 418.10415
Source: 2002 AACS.

R 418.10416
Source: 1998-2000 AACS.

R 418.10417
Source: 1998-2000 AACS.

PART 5. RADIOLOGY, RADIATION THERAPY, AND NUCLEAR MEDICINE

R 418.10501
Source: 2002 AACS.

R 418.10502
Source: 2002 AACS.

R 418.10503
Source: 2002 AACS.

PART 7. DENTAL

R 418.10701 Scope.
Rule 701. (1) Dental services, related to, or resulting from, a covered work-related injury are covered under these rules. Incidental dental services are not covered.
(2) A dental provider shall bill services on a standard American dental claim form**.** The workers' compensation agency shall publish a copy of the claim form and instructions for completion separate from these rules in the health care services manual.
(3) Dental services shall be reimbursed at either the dentist's usual and customary fee or reasonable fee, whichever is less.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

PART 9. BILLING
SUBPART A. PRACTITIONER BILLING

R 418.10901 General information.
Rule 901. (1) All health care practitioners and health care organizations, as defined in these rules, shall submit charges on the proper claim form as specified in this rule. Copies of the claim forms and instruction for completion for each form shall be published separate from these rules in a manual distributed by the health care services division of the workers' compensation agency. Charges shall be submitted as follows:
(a) A practitioner shall submit charges on the CMS1500 claim form.
(b) A doctor of dentistry shall submit charges on a standard dental claim form approved by the American dental association.
(c) A pharmacy, other than an inpatient hospital, shall submit charges on an invoice or a pharmacy universal claim form.
(d) A hospital-owned occupational, industrial clinic, or office practice shall submit charges on the CMS 1500 claim form.
(e) A hospital billing for a practitioner service shall submit charges on a CMS 1500 claim form.
(f) Ancillary service charges shall be submitted on the CMS 1500 claim form for durable medical equipment and supplies, L-code procedures, ambulance, vision, and hearing services. Charges for home health services shall be submitted on the UB-92 claim form.
(g) A shoe supplier or wig supplier shall submit charges on an invoice.
(2) A provider shall submit all bills to the carrier within 1 year of the date of service for consideration of payment, except in cases of litigation or subrogation.

(3) A properly submitted bill shall include all of the following appropriate documentation:
(a) A copy of the medical report for the initial visit.
(b) An updated progress report if treatment exceeds 60 days.
(c) A copy of the initial evaluation and a progress report every 30 days of physical treatment, physical or occupational therapy, or manipulation services.
(d) A copy of the operative report or office report if billing surgical procedure codes 10040-69990.
(e) A copy of the anesthesia record if billing anesthesia codes
00100-01999.
(f) A copy of the radiology report if submitting a bill for a radiology service accompanied by modifier -26. The carrier shall only reimburse the radiologist for the written report, or professional component, upon receipt of a bill for the radiology procedure.
(g) A report describing the service if submitting a bill for a "by report" procedure.
(h) A copy of the medical report if a modifier is applied to a procedure code to explain unusual billing circumstances.
History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10902 Billing for injectable medications, other than vaccines and toxoids, in office setting.
Rule 902. (1) The provider shall not bill the carrier for procedure codes 90782-90799, administration of therapeutic injections, if billed in conjunction with an evaluation and management procedure code. If an evaluation and management procedure code, 99201-99499, is not listed, then procedure codes 90782-90799 may be billed to describe the administration of the medication.
(2) The injection medication shall be billed with either 99070, the unlisted drug and supply code from physicians' current procedural terminology, (CPT®), or the specific J-code procedure from Medicare's National Level II Codes as adopted by reference in R 418.10107.
(3) The provider shall list the NDC or national drug code for the medication in box 19 or 24K of the CMS 1500.
(4) The carrier shall reimburse the medication at average wholesale price, (AWP) according to the Redbook, as adopted by reference in R 418.10107.
(5) If the provider does not list the national drug code for the medication, the carrier shall reimburse the medication using the least costly NDC listed by Redbook for that medication.
History: 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10904 Procedure codes and modifiers.
Rule 904. (1) A health care service shall be billed with procedure codes adopted from "Physicians' Current Procedural Terminology (CPT®)" or "HCPCS, Medicare's National Level II Codes," as referenced in R 418.10107. Procedure codes from "Physicians' Current Procedural Terminology (CPT®)" shall not be included in these rules, but shall be listed in a separate manual published by the workers' compensation agency. Refer to "Physicians' Current Procedural Terminology (CPT®)" for standard billing instructions, except where otherwise noted in these rules. A provider billing services described with procedure codes from "Medicare's National Level II Codes" shall refer to the publication as adopted by reference in R 418.10107 for coding information.
(2) The following ancillary service providers shall bill codes from "HCPCS, Medicare's National Level II Codes," as adopted by reference in R 418.10107, to describe the ancillary services:
(a) Ambulance providers.
(b) Certified orthotists and prosthetists.
(c) Medical suppliers, including expendable and durable equipment.
(d) Hearing aid vendors and suppliers of prosthetic eye equipment.
(3) A home health agency.
(4) If a practitioner performs a procedure that cannot be described by one of the listed CPT® or HCPCS codes, then the practitioner shall bill the unlisted procedure code. An unlisted procedure code shall only be reimbursed when the service cannot be properly described with a listed code and the documentation supporting medical necessity includes all of the following:
(a) Description of the service.
(b) Documentation of the time, effort, and equipment necessary to provide the care.
(c) Complexity of symptoms.
(d) Pertinent physical findings.
(e) Diagnosis.
(f) Treatment plan.

(5) The provider shall add a modifier code, found in Appendix A of the CPT® publication, as adopted by reference in R 418.10107, following the correct procedure code describing unusual circumstances arising in the treatment of a covered injury or illness. When a modifier code is applied to describe a procedure, a report describing the unusual circumstances shall be included with the charges submitted to the carrier.
(6) Applicable modifiers from table 10904 shall be added to the procedure code to describe the type of practitioner performing the service. The required modifier codes for describing the practitioner are as follows:

Table 10904
Modifier Codes

-AA	Anesthesia services performed personally by anesthesiologist
-AH	When a licensed psychologist bills a diagnostic service or a therapeutic service, or both.
-AJ	When a certified social worker bills a therapeutic service.
-AL	A limited license psychologist billing a diagnostic service or a therapeutic service.
-CS	When a limited licensed counselor bills for a therapeutic service.
-GF	Non-physician (nurse practitioner, advanced practice nurse or physician assistant) provides services in an office or clinic setting or in a hospital setting**.**
-LC	When a licensed professional counselor performs a therapeutic service.
-MF	When a licensed marriage and family therapist performs a therapeutic service.
-ML	When a limited licensed marriage and family therapist performs a service.
-TC	When billing for the technical component of a radiology service.
-QK	When an anesthesiologist provides medical direction for not more than 4 qualified individuals being either certified registered nurse anesthetists or anesthesiology residents
-QX	When a certified registered nurse anesthetist performs a service under the medical direction of an anesthesiologist.
-QZ	When a certified registered nurse anesthetist performs anesthesia services without medical direction.

History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10905
Source: 1998-2000 AACS.

R 418.10907 Billing codes for site of service and type of service.
Rule 907. (1) A practitioner, other than a dentist, when billing practitioner services, shall identify the site of service and type of service with numerical codes consistently used in the industry. The health care services division of the workers' compensation agency shall publish the numerical codes in the Health Care Services Manual separate from these rules.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10909
Source: 2002 AACS.

R 418.10911
Source: 1998-2000 AACS.

R 418.10912 Billing for prescription medications.
Rule 912. (1) Prescription drugs may be dispensed to an injured worker by either an outpatient pharmacy or a health care organization as defined in these rules. These rules shall apply to the pharmacy dispensing the prescription drugs to an injured worker only after the pharmacy has either written or oral confirmation from the carrier that the prescriptions or supplies are covered by workers' compensation insurance.
(2) When a generic drug exists, the generic drug shall be dispensed. When a generic drug does not exist, the brand name drug may be dispensed. A physician may only write a prescription for "DAW", or dispense as written, when the generic drug has been utilized and found to be ineffective or has caused adverse effects for the injured worker. A copy of the medical record documenting the medical necessity for the brand name drug shall be submitted to the carrier.
(3) A bill or receipt for a prescription drug from an outpatient pharmacy, practitioner, or health care organization shall be submitted to the carrier and shall include the name, address, and social security number of the injured worker. An outpatient pharmacy shall bill the service using the universal pharmacy claim form or an invoice and shall include the national association board of pharmacy identification number and the serial number of the prescription drug.

(4) A health care organization or physician office dispensing the prescription drug shall bill the service on the CMS 1500 claim form. Procedure code 99070 shall be used to code the service and the national drug code shall be used to describe the drug.
(5) If an injured worker has paid for a prescription drug for a covered work illness, then the worker may send a receipt showing payment along with the drug information to the carrier for reimbursement.
(6) An outpatient pharmacy or health care organization shall include all of the following information when submitting a bill for a prescription drug to the carrier:
(a) The brand or chemical name of the drug dispensed.
(b) The manufacturer or supplier's name and the NDC, or national drug code from the "Red Book" as adopted by reference in R 418.10107.
(c) The dosage, strength, and quantity dispensed.
(d) The date the drug was dispensed.
(e) The physician prescribing the drug.
(7) A practitioner or a health care organization, other than an inpatient hospital, shall bill WC700 to describe the dispense fee for each prescription drug. A provider will only be reimbursed for 1 dispense fee for each prescription drug in a 10-day period. A dispense fee shall not be billed with "OTC"s, over-the-counter drugs.
History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10913
Source: 1998-2000 AACS.

R 418.10915 Billing for anesthesia services.
Rule 915. (1) Anesthesia services shall consist of 2 components. The 2 components are base units and time units. Each anesthesia procedure code is assigned a value for reporting the base units. The base units for an anesthesia procedure shall be as specified in the publication entitled "Medicare RBRVS: The Physicians' Guide" as adopted by reference in R 418.10107. The anesthesia codes**,** base units and instructions for billing the anesthesia service shall be published separate from these rules in the health care services manual.
(2) An anesthesia service may be administered by either an anesthesiologist, anesthesia resident, a certified registered nurse anesthetist, or a combination of a certified registered nurse anesthetist, and a physician providing medical direction or supervision. When billing for both the anesthesiologist and a certified registered nurse anesthetist, the anesthesia procedure code shall be listed on 2 lines of the CMS 1500 with the appropriate modifier on each line.
(3) One of the following modifiers shall be added to the anesthesia procedure code to determine the appropriate payment for the time units:
(a) Modifier -AA indicates the anesthesia service is administered by the anesthesiologist.
(b) Modifier –QK indicates the anesthesiologist has provided medical direction for a certified registered nurse anesthetist, CRNA, or resident. The CRNA or resident may be employed by either a hospital, the anesthesiologist or may be self-employed.
(c) Modifier -QX indicates the certified registered nurse anesthetist has administered the procedure under the medical direction of the anesthesiologist.
(d) Modifier -QZ indicates the certified registered nurse anesthetist has administered the complete anesthesia service without medical direction of an anesthesiologist.
(4) Total anesthesia units shall be calculated by adding the anesthesia base units to the anesthesia time units.
(5) Anesthesia services may be administered by any of the following:
(a) A licensed doctor of dental surgery.
(b) A licensed doctor of medicine.
(c) A licensed doctor of osteopathy.
(d) A licensed doctor of podiatry.
(e) A certified registered nurse anesthetist.
(f) A licensed anesthesiology resident.
(6) If a surgeon provides the anesthesia service, the surgeon will only be reimbursed the base units for the anesthesia procedure.
(7) If a provider bills physical status modifiers, then documentation shall be included with the bill to support the additional risk factors. When billed, the physical status modifiers are assigned unit values as defined in the following table:

	Anesthesiology Physical Status Modifiers	**Unit Value**
P1	A normal healthy patient.	0

	Anesthesiology Physical Status Modifiers	Unit Value
P2	A patient who has a mild systemic disease.	0
P3	A patient who has a severe systemic disease.	1
P4	A patient who has a severe systemic disease that is a constant threat to life.	2
P5	A moribund patient who is expected not to survive without the operation.	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes.	0

(8) Procedure code 99140 shall be billed as an add-on procedure if an emergency condition, as defined in R 418.10108, complicates anesthesia. Procedure code 99140 shall be assigned 2 anesthesia units. Documentation supporting the emergency shall be attached to the bill.
(9) If a pre-anesthesia evaluation is performed and surgery is not subsequently performed, then the service shall be reported as an evaluation and management service.
History: 2000 MR 6, Eff. May 11, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10916
Source: 2003 AACS.

R 418.10918
Source: 2002 AACS.

R 418.10920
Source: 1998-2000 AACS.

PART 9. BILLING
SUBPART B. FACILITY BILLING

R 418.10921 Facility billing.
Rule 921. (1) Except for a freestanding surgical outpatient facility**,** a licensed facility as defined in these rules shall submit facility charges on a UB-92 claim form to the carrier. A copy of the UB-92 form shall be published separate from these rules in a manual distributed by the health care services division of the agency. The Michigan uniform billing manual referenced in these rules contains instructions for facility billing.
(2) A facility billing for a practitioner service shall bill charges on the CMS 1500 claim form.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10922
Source: 2003 AACS.

R 418.10923 Hospital billing for practitioner services.
Rule 923. (1) A hospital billing for practitioner services, including a certified registered nurse anesthetist, a physician, a nurse who has a specialty certification, and a physician's assistant, shall submit bills on a CMS 1500 form and the hospital shall use the appropriate procedure codes adopted by these rules. A hospital shall bill for professional services provided in the hospital clinic setting as practitioner services on a CMS 1500 form using outpatient hospital for the site of service. A hospital or hospital system-owned office practice shall bill all office services as practitioner services on a CMS 1500 form using office or clinic for the site of service. A hospital or hospital system-owned industrial or occupational clinic providing occupational health services for injured workers shall bill all clinic services as practitioner services on a CMS 1500 using office or clinic for the site of service. A hospital or hospital system-owned industrial or occupational clinic shall not use emergency department evaluation and management procedure codes. Radiology and laboratory services may be billed as facility services on the UB-92.
(2) A hospital billing for the professional component of a medical service, excluding physical medicine, occupational medicine, or speech and hearing services shall bill the service on a CMS 1500 claim form adding modifier –26 identifying the bill is for the professional component of the service. The bill shall indicate outpatient hospital for the site of service. The carrier shall pay the maximum allowable fee listed in the manual for the professional component of the procedure. If the professional component is not listed, then the carrier shall pay 40% of the maximum allowable fee.
(3) A hospital billing for a radiologist's or pathologist's services shall bill the professional component of the procedure on the CMS 1500 claim form and shall place modifier -26 after the appropriate procedure code to identify the professional component of the service. The carrier shall pay the maximum allowable fee listed in the manual for the professional

component of the procedure. If the professional component is not listed, then the carrier shall pay 40% of the maximum allowable fee.
(4) A hospital billing for a certified registered nurse anesthetist shall bill only time units of an anesthesiology procedure and use modifier –QX with the appropriate anesthesia code, except in the absence of medical direction from a supervising anesthesiologist.
History: 2000 MR 6, Eff. May 11, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10923B Billing for freestanding surgical outpatient facility,(FSOF).
Rule 923B (1) A freestanding surgical outpatient facility (FSOF) shall be licensed by the department of public health, bureau of health systems, under part 208 of the code. The owner or operator of the facility shall make the facility available to other physicians, dentists, podiatrists or providers who comprise its professional staff.
(a) When a surgery procedure is appropriately performed in the freestanding surgical outpatient facility and Medicare has not assigned a grouper number for that procedure, the procedure shall be considered by report. The freestanding surgical outpatient facility shall be reimbursed either the usual and customary charge or reasonable charge, whichever is less for the procedure.
(2) Billing instructions in this rule do not apply to a hospital-owned freestanding surgical outpatient facility billing with the same tax identification number as the hospital.
(3) A freestanding surgical outpatient facility, licensed by the state, shall bill the facility services on the CMS 1500 claim form and shall include modifier SG to identify the service as the facility charge. The place of service shall be "24." The appropriate HCPCS or CPT® procedure code describing the service performed shall be listed on separate lines of the bill.
(4) Modifier 50, generally indicating bilateral procedure is not valid for the FSOF claim. Procedures performed bilaterally shall be billed on two separate lines of the claim form and shall be identified with modifiers, LT for left and RT for right.
(5) A freestanding surgical outpatient facility shall only bill for outpatient procedures which, in the opinion of the attending physician, can be performed safely without requiring inpatient overnight hospital care and are exclusive of such surgical and related care as licensed physicians ordinarily elect to perform in their private offices.
(6) The CPT® procedure code billed by the facility is classified according to 1 of 9 groupers, as determined by center for Medicare and Medicaid services. The grouper number for each procedure code is published in the federal register.
(7) The payment for the surgical code includes the supplies for the procedure.
(8) Laboratory procedures, durable medical equipment, radiology services, and items implanted into the body that remain in the body at discharge from the facility may be billed separately.
(9) The facility shall bill implant items with the unlisted CPT® drug and supply code, 99070. A report listing a description of the implant and a copy of the facility's cost invoice shall be included with the bill. Some examples of implant items are plates, pins, screws, mesh.
(10) When radiology procedures are performed intra-operatively, only the technical component shall be billed by the facility and reimbursed by the carrier. The professional component shall be included with the surgical procedure. Pre-operative and postoperative radiology services may be globally billed.
(11) At no time shall the freestanding surgical outpatient facility bill for practitioner services on the facility bill.
History: 2005 MR 2, Eff. Feb. 10, 2005.

R 418.10924
Source: 2003 AACS.

R 418.10925 Billing requirements for other licensed facilities.
Rule 925. (1) A licensed facility, other than a hospital or freestanding surgical outpatient facility, shall bill the facility services on the UB-92 national uniform billing claim form and shall include the revenue codes contained in the Michigan Uniform Billing Manual, ICD-9-CM coding for diagnoses and procedures, and CPT® procedure codes for surgical, radiological, laboratory, and medicine and evaluation and management services.
(2) Only the technical component of a radiological service or a laboratory service shall be billed on the standardized UB-92 national uniform billing claim form.
(3) All bills for the professional services shall be billed on a CMS 1500 claim form, using the appropriate CPT® procedure code and modifier
(4) A report describing the services provided and the condition of the patient shall be included with the bill.
History: 2000 MR 6, Eff. May 11, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

PART 10. REIMBURSEMENT

SUBPART A. PRACTITIONER REIMBURSEMENT

R 418.101001 General rules for practitioner reimbursement.
Rule 1001. (1) A provider that is authorized to practice in the state of Michigan shall receive the maximum allowable payment in accordance with these rules. A provider shall follow the process specified in these rules for resolving differences with a carrier regarding payment for appropriate health care services rendered to an injured worker.
(2) A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.
(3) A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.
(4) A carrier shall pay, adjust, or reject a properly submitted bill within 30 days of receipt. The carrier shall notify the provider on a form entitled "Carrier's Explanation of Benefits" in a format specified by the workers' compensation agency. A copy shall be sent to the injured worker.
(5) A carrier shall not make a payment for any service which is determined inappropriate by the carrier's professional health care review program.
(6) The carrier shall reimburse the provider a 3% late fee if more than 30 calendar days elapse between a carrier's receipt of a properly submitted bill and a carrier's mailing of the payment.
(7) If a procedure code has a maximum fee of "by report," the provider shall be paid usual and customary charge or the reasonable amount, whichever is less. The carrier shall provide an explanation of its determination that the fee is unreasonable or excessive in accordance with these rules.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101002 Conversion factors for medical, surgical, and radiology procedure codes.
Rule 1002. (1) The workers' compensation agency shall determine the conversion factors for medical, surgical, and radiology procedures. The conversion factor shall be used by the workers' compensation agency for determining the maximum allowable payment for medical, surgical, and radiology procedures. The maximum allowable payment shall be determined by multiplying the appropriate conversion factor times the relative value unit assigned to a procedure. The relative value units are listed for the medicine, surgical, and radiology procedure codes in a manual separate from these rules. The manual shall be published annually by the workers' compensation agency using codes adopted from "Physicians' Current Procedural Terminology (CPT®)" as referenced in R 418.10107(a). The workers' compensation agency shall determine the relative values by using information found in the "Medicare RBRVS: The Physicians'Guide" as adopted by reference in R 418.10107(c).
(2) The conversion factor for medicine, radiology, and surgical procedures shall be $48.49 for the year 2005 and shall be effective for dates of service on or after the effective date of these rules.
History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2002 MR 1, Eff. Jan. 11, 2002; 2003 MR 4, Eff. Mar. 4, 2003; 2004 MR 5, Eff. Feb.20, 2004; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101003 Reimbursement for "by report" and ancillary procedures.
Rule 1003. (1) If a procedure code does not have a listed relative value or is noted BR, then the carrier shall reimburse the provider's usual and customary charge or reasonable payment, whichever is less, unless otherwise specified in these rules.
(2) The following ancillary services are by report and the provider shall be reimbursed either at the practitioner's usual and customary charge or reasonable payment, whichever is less:
(a) Ambulance services.
(b) Dental services.
(c) Vision and prosthetic optical services.
(d) Hearing aid services.
(3) Prescription medication shall be reimbursed at the average wholesale price (AWP) + a $4.00 dispense fee for each drug, as determined by the Red Book, referenced in R 418.10107(e).
(4) Over-the-counter drugs (OTC's), dispensed by a provider other than a pharmacy, shall be dispensed in 10-day quantities and shall be reimbursed at the average wholesale price, as determined by the Red Book, or $2.50, whichever is greater.
(5) Durable medical equipment, supplies, including pre-fabricated splints, shall be reimbursed by the carrier at the average wholesale price, plus not more than 50%, or the provider's usual and customary charge, whichever is less.
(6) Orthotic and prosthetic procedures, L0100-L8499, and assigned maximum allowable payments shall be listed in R 418.101504.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101004 Modifier code reimbursement.

Rule 1004. (1) When accompanied by a modifier code, a procedure code shall be considered to have a maximum allowable payment of BR, except as provided for by subrules (2) to (13) of this rule.
(2) When modifier code -25 is added to an evaluation and management procedure code, reimbursement shall only be made when the documentation provided supports the patient's condition required a significant separately identifiable evaluation and management service other than the other service provided or beyond the usual preoperative and postoperative care**.**
(3) When modifier code -26, professional component, is used with a radiology procedure, the payment shall be determined by multiplying the relative value for the professional component times the radiology conversion factor.
(4) If a surgeon uses modifier code -47 when performing a surgical procedure, then anesthesia services were provided by the surgeon and the maximum allowable payment for the anesthesia portion of the service shall be calculated by multiplying the base unit of the appropriate anesthesia code by $42.00. No additional payment is allowed for time units.
(5) When modifier code -50 or -51 is used with procedure codes 10000-69999, a doctor of dental surgery, doctor of medicine, doctor of osteopathy, or doctor of podiatry shall be paid the following:
(a) The primary procedure at not more than 100% of the maximum allowable payment or the billed charge, whichever is less.
(b) The secondary procedure and the remaining procedure or procedures at not more than 50% of the maximum allowable payment or the billed charge, whichever is less.
(c) When multiple injuries occur in different areas of the body, the first surgical procedure in each part of the body shall be reimbursed 100% of the maximum allowable payment or billed charge, whichever is less, and the second and remaining surgical procedure or procedures shall be identified by modifier code -51 and shall be reimbursed at 50% of the maximum allowable payment or billed charges, whichever is less.
(d) When modifier -50 or -51 is used with a surgical procedure with a maximum allowable payment of BR, the maximum allowable payment shall be 50% of the provider's usual and customary charge or 50% of the reasonable amount, whichever is less.
(6) When modifier code -TC, technical services, is used to identify the technical component of a radiology procedure, payment shall be made for the technical component only. The maximum allowable payment for the technical portion of the radiology procedure is designated in the manual by -TC.
(7) When modifier -57, initial decision to perform surgery, is added to an evaluation and management procedure code, the~~n~~ modifier -57 shall indicate that a consultant has taken over the case and the consultation code is not part of the global surgical service.
(8) When both surgeons use modifier -62 and the procedure has a maximum allowable payment, the maximum allowable payment for the procedure shall be multiplied by 25%. Each surgeon shall be paid 50% of the maximum allowable payment times 25%, or 62.5 % of the MAP. If the maximum allowable payment for the procedure is BR, then the reasonable amount shall be multiplied by 25% and be divided equally between the surgeons.
(9) When modifier code -80 is used with a procedure, the maximum allowable payment for the procedure shall be 20% of the maximum allowable payment listed in these rules, or the billed charge, whichever is less. If a maximum payment has not been established and the procedure is BR, then payment shall be 20% of the reasonable payment amount paid for the primary procedure.
(10) When modifier code -81 is used with a procedure code that has a maximum allowable payment, the maximum allowable payment for the procedure shall be 13% of the maximum allowable payment listed in these rules or the billed charge, whichever is less. If modifier code -81 is used with a BR procedure, then the maximum allowable payment for the procedure shall be 13% of the reasonable amount paid for the primary procedure.
(11) When modifier -82 is used and the assistant surgeon is a licensed doctor of medicine, doctor of osteopathic medicine and surgery, doctor of podiatric medicine, or a doctor of dental surgery, the maximum level of reimbursement shall be the same as for modifier -80. If the assistant surgeon is a physician's assistant, the maximum level of reimbursement shall be the same as modifier -81. If a person other than a physician or a certified physician's assistant bills using modifier -82, then the charge and payment for the service is reflected in the facility fee.
(12) When modifier –GF is billed with evaluation and management or minor surgical services, the carrier shall reimburse the procedure at 85% of the maximum allowable payment, or the usual and customary charge, whichever is less.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101005
Source: 2002 AACS.

R 418.101006
Source: 1998-2000 AACS.

R 418.101007

Source: 1998-2000 AACS.

PART 10. REIMBURSEMENT
SUBPART B. FACILITY REIMBURSEMENT

R 418.101015 General rules for facility reimbursement.
Rule 1015. (1) A facility licensed by the state of Michigan shall receive the maximum allowable payment in accordance with these rules. The facility shall follow the process specified in these rules for resolving differences with a carrier regarding payment for the appropriate health care services rendered to an injured worker.
(2) The carrier or its designated agent shall assure that the UB-92 national uniform billing claim form, (D1450), is completed correctly before payment. A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.
(3) A carrier shall pay, adjust or reject a properly submitted bill within 30 days of receipt, sending notice on a form entitled " Carrier's Explanation of Benefits" in a format specified by the agency. The carrier shall reimburse the facility a 3% late fee if more than 30 days elapse between a carrier's receipt of a properly submitted bill and a carrier's mailing of the payment.
(4) Submission of a correctly completed UB-92 claim form shall be considered to be a properly submitted bill. The following medical records shall also be attached to the facility charges as applicable:
Emergency room report.
The initial evaluations and progress reports every 30 days whenever physical medicine, speech and hearing services are billed by a facility.
The anesthesia record whenever the facility bills for the services of a CRNA or anesthesiologist.
(5) Additional records not listed in subrule (4) of this rule may be requested by the
carrier and shall be reimbursed in accordance with R 418.10118.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101016 Reimbursement for hospital facility services.
Rule 1016. (1) A hospital licensed in Michigan billing facility services shall be reimbursed using the maximum payment ratio methodology for the following services:
Inpatient or observation care.
Emergency department services.
(c) Occupational, physical, and speech therapy services.
(d) Outpatient surgeries.
(e) Laboratory services and outpatient services not listed on Table 10922.
If a carrier pays a properly submitted bill or unadjusted portion of the bill within 30 days of receipt, then the payment is calculated by multiplying the charges times the hospital's maximum payment ratio times a multiplier of 107%. If a carrier pays the bill after 30 days, then the multiplier shall be 110% allowing for a 3% late fee.
(2) When a hospital outside the state of Michigan submits a bill for facility services, the carrier may initially process payment by using the method described in subrule (1) applying the average maximum payment ratio, as published in the health care services manual. If the facility located outside of Michigan does not accept reimbursement according to Michigan health care services rules, then the carrier shall negotiate the charges with the out-of-state facility and reimburse the facility according to the laws of the state where the facility is located.
(3) If applying the ratio methodology results in an amount greater than the hospital's charge, the carrier shall reimburse the hospital's charge. The only time a carrier shall pay in excess of the charge is if a properly submitted bill was not paid within 30 days and, in that instance, the carrier shall reimburse the charge plus a 3% late fee.
(4) Observation care shall not be for more than 24 hours. If the patient does not meet admission criteria according to the length of stay guidelines, then the patient shall be discharged from observation care.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101017 Reimbursement for outpatient minor medical-surgical procedures performed in outpatient hospital setting when billed on UB-92.
Rule 1017. (1) Reimbursement for services listed on Table 10922 shall be made as follows:
(a) If the service occurs in the first 10 days of care beginning for a work injury, then the hospital shall be reimbursed by the ratio methodology. The ratio methodology shall be used to reimburse the hospital facility for the following services:
Outpatient surgery.
Appropriate emergency room visits.
Inpatient hospitalization or 24-hour outpatient observation stays.

(b) If the service occurs after the first 10 days, then the carrier shall reimburse the facility for the technical component of the procedure, or 60% of the maximum allowable payment for those minor medical**,** surgical and radiology procedures.
(2) This rule shall not apply to services performed in a hospital-owned or hospital-system owned occupational or industrial clinics or departments, as those services shall be considered practitioner services and shall be billed and paid as a practitioner service.
History: 2000 MR 6, Eff. May 11, 2000; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101018
Source: 1998-2000 AACS.

R 418.101019
Source: 1998-2000 AACS.

R 418.101022 Facility reimbursement excluding hospital or freestanding surgical outpatient facility.
Rule 1022. (1) When the following licensed facilities provide services to an injured worker and bill the carrier, the billed services shall be considered by report:
(a) Nursing home.
(b) County medical care facility.
(c) Hospice.
(d) Hospital long-term care unit.
(e) Intermediate care facility or skilled nursing facility.
(2) A licensed facility in subrule (1) of this rule shall be reimbursed by its usual and customary charge or reasonable amount for the service provided, whichever is less. If a carrier does not reimburse the facility within 30 days of receipt of a properly submitted bill, the carrier shall reimburse the facility an additional 3% late fee.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. FEb. 10, 2005.

R 418.101023 Reimbursement for a freestanding surgical outpatient facility service.
Rule 1023. (1) Reimbursement for surgical procedures performed in a freestanding surgical outpatient facility shall be determined by using grouper rates as determined by Medicare and published in the Federal Register. The surgical procedures shall be classified into 1 of 9 groupers, numbered 1-9. An allowable rate is assigned to each grouper and the payment is determined by multiplying the grouper rate times a wage index. The rates for the groupers shall be published by the agency in the Health Care Services Manual. The wage index shall be determined by the workers' compensation agency and shall be published in the Health Care Services Manual.
(2) The state of Michigan workers' compensation health care services rules shall adopt the payment system described in subrule 1 of this rule adding 80% to the rate reflecting a payment that is 80% higher than Medicare. The geographical wage-index used to calculate the payment for the surgical procedures shall be 1.0147, representing urban Michigan. The formula for determining the maximum allowable payment (MAP) for a surgical procedure performed in a freestanding surgical outpatient facility shall be as follows: (grouper rate) x (1.8) x (wage-index of 1.0147).
(3) When 2 or more surgical procedures are performed in the same operative session, the facility shall be reimbursed at 100% of the maximum allowable payment or the facility's usual and customary charge, whichever is less, for the procedure classified in the highest payment group. Any other surgical procedures performed during the same session shall be reimbursed at 50% of the maximum allowable payment or 50% of the facility's usual and customary charge, whichever is less. A facility may not un-bundle surgical procedure codes when billing the services.
(4) When an eligible procedure is performed bilaterally, each procedure shall be listed on a separate line of the claim form and shall be identified with LT for left and RT for right. At no time shall modifier 50 be used by the facility to describe bilateral procedures.
(5) When an item is implanted during the surgical procedure and the freestanding surgical outpatient facility bills the implant and includes the copy of the invoice, the implant shall be reimbursed at the cost of the implant plus a percent mark-up as follows:
(a) Cost of implant: $1.00-$500.00 shall receive cost + 50%.
(b) Cost of implant: $500.01-$1000.00 shall receive cost + 30%.
(c) Cost of implant: $1000.01 and higher shall receive cost + 25%.
(6) Laboratory services shall be reimbursed by the maximum allowable payment as determined in R 418.101503.
(7) When a radiology procedure is performed intra-operatively, only the technical component shall be billed by the facility and reimbursed by the carrier. The professional component shall be included with the surgical procedure. Pre-operative and postoperative radiology services may be globally billed.

(8) When the freestanding surgical facility provides durable medical equipment, the items shall be reimbursed in accord with R 418.101003 (5).
History: 2005 MR 2, Eff. Feb. 10, 2005.

PART 11. HOSPITAL PAYMENT RATIO

R 418.101101 Calculation and revision of payment ratio for Michigan hospitals.
Rule 1101. (1) The workers' compensation agency shall annually calculate and revise, under the provisions of 1969 PA 306**,** 24.201 et seq. MCL**,** the payment ratios for all Michigan hospitals. The calculation shall be made using a hospital's most recent fiscal year information that is submitted to the Michigan department of community health, medical services administration, preceding each annual calculation. The information used shall be that reported to the Michigan department of community health, medical services administration, on the hospital's statement of patient revenues and operating expenses, G2 worksheet. The workers' compensation agency shall complete the payment ratio calculation between September 1 and October 1, or the earliest date when the figures are available from Michigan department of community health and shall annually publish the hospital ratio calculations in a separate manual effective for dates of service on or after the effective date of these rules.
(2) The workers' compensation agency shall calculate a hospital's cost-to-charge ratio by dividing each hospital's total operating expenses by total patient revenues as reported on the hospital's statement of patient revenues and operating expenses, G2 worksheet.
History: 2000 MR 6, Eff. May 11, 2000; 2004 MR 5, Eff. Feb. 20, 2004; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101102 Calculation and revision of payment ratio for hospitals outside Michigan.
Rule 1102. The workers' compensation agency shall annually calculate and revise, under the provisions of 1969 PA 306, as amended, being §24.201 et seq. of the MCL, at the same time as calculating Michigan hospitals' payment ratios, a weighted state average payment ratio to be used for hospitals that are located outside the state of Michigan. The payment ratio shall be calculated by dividing the total hospital operating expenses for Michigan by the total hospital patient revenues for Michigan as reported under R 418.1101(1).
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101103 Adjustments to hospital's payment ratio.
Rule 1103. (1) A hospital may apply to the agency for an adjustment of the hospital's maximum payment ratio.
(2) The hospital shall apply for an adjustment on a form and in a manner prescribed by the workers' compensation agency.
(3) If the agency determines that a hospital's ratio of total operating expenses to total patient revenues, as reported on the hospital's statement of patient revenues and operating expenses, G2 worksheet, for a hospital's most recent fiscal year is higher than the payment ratio calculated according to R 418.1101, so that the amount of underpayment is more than $100,000.00 or is equal to or greater than 2/10 of 1% of the hospital's operating expenses for the year, then the agency shall revise the payment ratio and shall notify the hospital and all carriers of the revised payment ratio within 45 days after the receipt of a properly submitted request for an adjustment.
(4) If a hospital's request for an adjustment to the hospital's payment ratio is denied by the workers' compensation agency, then a hospital may request reconsideration and appeal of the agency's action regarding the hospital's request for adjustment of its payment ratio.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101104 Request for adjustment to hospital's maximum payment ratio; agency's response.
Rule 1104. (1) Within 60 days of the agency's receipt of a hospital's request for adjustment to the hospital's maximum payment ratio, the workers' compensation agency shall notify the hospital of the action on the adjustment request and shall notify the hospital of the hospital's right to provide additional information to request reconsideration of the agency's action.
(2) The workers' compensation agency shall also furnish the hospital with an appeal form. The appeal form shall include an explanation of the appeal process.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101105 Agency's action on request for adjustment of maximum payment ratio; hospital's appeal.
Rule 1105. (1) If a hospital is in disagreement with the action taken by the workers' compensation agency on its request for adjustment of the hospital's maximum payment ratio, then a hospital may, within 30 days of receipt of the agency's action on the hospital's request for adjustment to its maximum payment ratio, deliver or mail an appeal of the agency's action to the agency. The appeal shall include a detailed statement of the reasons for disagreement and shall request reconsideration of the

agency's action on the hospital's request for adjustment.
(2) The workers' compensation agency shall hold a hearing within 30 days of the receipt of a hospital's appeal under section 847 of the act.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

PART 12. CARRIER'S REVIEW OF HEALTH CARE REVIEW

R 418.101201
Source: 1998-2000 AACS.

R 418.101203
Source: 1998-2000 AACS.

R 418.101204 Carrier's professional health care review program.
Rule 1204. (1) A carrier may have another entity perform professional health care review activities on its behalf.
(2) The workers' compensation agency shall certify a carrier's professional health care review program pursuant to R 418.101206.
(3) The carrier shall submit a completed form entitled "Application for Certification of the Carrier's Professional Health Care Review Program" to the agency. If the carrier is a self-insured employer or self-insured group fund, then the service company information shall be included on the form in addition to the carrier and review company information. In addition to the completed form, the carrier shall submit all of the following:
(a) The methodology used to perform professional review.
(b) A listing of the licensed, registered, or certified health care professionals reviewing the health care bills or establishing guidelines for technical review. In addition, the proof of current licensure and qualifications for the health care professionals shall be included with the completed application.
(c) A list of the carrier's peer review staff, including specialty.
(4) The workers' compensation carrier as defined by these rules maintains full responsibility for compliance with these rules.
(5) The carrier shall determine medical appropriateness for the services provided in connection with the treatment of a covered injury or illness, using published, appropriate standard medical practices and resource documents. Utilization review shall be performed using 1 or both of the following approaches:
(a) Review by licensed, registered, or certified health care professionals.
(b) The application by others of criteria developed by licensed, registered, or certified health care professionals.
(6) The licensed, registered, or certified health care professionals shall be involved in determining the carrier's response to a request by a provider for reconsideration of its bill.
(7) The licensed, registered, or certified health care professionals shall have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided.
(8) When peer review is utilized, a health care professional of the same specialty type as the provider of the medical service shall perform the review.
History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101205 Scope of professional health care review.
Rule 1205. (1) The carrier, or it's review company, shall review case records and health-service bills, or both, under the professional health care review program as follows:
(a) A case where health care service payments, excluding inpatient hospital care, exceed $20,000.00.
(b) A case involving inpatient hospital care.
(2) The carrier or other entity may at any time review any case record or bill which the carrier or the other entity believes may involve inappropriate, insufficient, or excessive care.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101206 Certification of professional health care review program.
Rule 1206. (1) The workers' compensation agency shall certify the carrier's professional health care review program.
(2) A carrier, or the reviewing entity on behalf of the carrier, shall apply to the agency for certification of a carrier's professional health care review program in the manner prescribed by the workers' compensation agency. The carrier shall submit a copy of "The Carriers Explanation of Benefits" form utilized to notify providers of payment decisions.
(3) A carrier shall receive certification if the carrier or the carrier's review company provides to the agency a description of

its professional health care review program and includes all of the information specified in R 418.101204. The workers' compensation agency shall send a copy of the certification of the carrier's review program to the carrier, and to the service company and review company when appropriate.
History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101207 Types of certification.
Rule 1207. (1) Certification shall be either unconditional or conditional.
(2) The workers' compensation agency shall issue unconditional certification for a period of 3 years.
(3) The agency may issue conditional certification if it is determined that the carrier or other entity does not fully satisfy the criteria in R 418.101206(3). If the carrier or other entity agrees to undertake corrective action, then conditional certification shall be granted by the agency for a maximum period of 1 year.
(a) If the workers' compensation agency receives multiple written complaints regarding a carrier, or the carrier's review process, and the agency determines the complaints are valid, or that the carrier has not processed payment for medical services in accord with these rules, then the agency may issue conditional certification.
(4) The workers' compensation agency may at any time modify an unconditional certification to a conditional certification if the agency determines that the carrier or other entity fails to satisfy the criteria set forth in R 418.101206(3).
(5) The carrier shall have the right to appeal the certification decisions under the procedures in these rules.
History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101208 Renewal of certification.
Rule 1208. (1) A carrier or other entity shall apply to the workers' compensation agency for renewal of certification in the manner prescribed by the agency, submitting the application 6 months prior to the expiration date on the certification.
(2) A carrier or other entity shall receive renewal of certification upon receipt of an updated description of its program as specified in R 418.101206.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101209 Carrier's request for reconsideration of professional review certification.
Rule 1209. (1) Within 30 days of the agency's denial of a carrier's request for professional review program certification, the agency shall notify the carrier of the reasons for denial of the certification and shall notify the carrier of its right to request reconsideration of the denial providing additional information.
(2) A carrier shall notify the agency, within 30 days of receipt of the professional review program certification denial, of its disagreement with the action of the agency. The carrier's notice to the agency of disagreement with the agency's denial shall include a detailed statement of the reasons for the disagreement and shall request reconsideration.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101210 Carrier's request for reconsideration of professional review program certification; response.
Rule 1210. (1) Within 30 days of receipt of a carrier's request for reconsideration of professional review program certification, the workers' compensation agency shall notify the carrier of the actions taken and shall furnish a detailed statement of the reasons for the action taken.
(2) The agency shall furnish the carrier with an appeal form. The appeal form shall include an explanation of the appeal process.
(3) If a carrier is in disagreement with the action taken by the agency on its request for reconsideration, then a carrier shall deliver or mail its appeal to the agency.
(4) The workers' compensation agency shall hold a hearing within 30 days of the receipt of a carrier's appeal of the agency's decision regarding certification of the carrier's professional review program under section 847 of the act.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

PART 13. PROCESS FOR RESOLVING DIFFERENCES BETWEEN CARRIER AND PROVIDER REGARDING BILL

R 418.101301 Carrier's adjustment or rejection of properly submitted bill.
Rule 1301. (1) If a carrier adjusts or rejects a bill or a portion of the bill, then the carrier shall notify the provider within 30 days of the receipt of the bill of the reasons for adjusting or rejecting the bill or a portion of the bill and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action. The carrier shall set forth the specific reasons for adjusting or rejecting a bill or a portion of the bill and request specific information on a

form, "Carrier's Explanation of Benefits," prepared by the agency pursuant to the reimbursement section of these rules.
(2) If the provider sends a properly submitted bill to a carrier and the carrier does not respond within 30 days, and if a provider sends a second properly submitted bill and does not receive a response within 60 days from the date the provider supplied the first properly submitted bill, then the provider may file an application with the agency for mediation or hearing. The provider shall send a completed form entitled "Application for Mediation and Hearing" to the agency and shall send a copy of this form to the carrier.
(3) The carrier shall notify the employee and the provider that the rules prohibit a provider from billing an employee for any amount for health care services provided for the treatment of a covered work-related injury or illness if that amount is disputed by the carrier under its utilization review program or if the amount is more than the maximum allowable payment established by these rules. The carrier shall request the employee to notify the carrier if the provider bills the employee.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101302
Source: 1998-2000 AACS.

R 418.101303 Provider's request for reconsideration of bill; carrier's response to provider's right to appeal.
Rule 1303. (1) Within 30 days of receipt of a provider's request for reconsideration, the carrier shall notify the provider of the actions taken and provide a detailed statement of the reasons. The carrier's notification shall include an explanation of the appeal process provided under these rules, including the fact that any requested administrative appeal hearing shall be conducted by a magistrate of the department of labor & economic growth.
(2) If a provider disagrees with the action taken by the carrier on the provider's request for reconsideration, then a provider may file an application for mediation or hearing with the department of labor & economic growth. A provider shall send its application for mediation or hearing to the agency within 30 days from the date of receipt of a carrier's denial of the provider's request for reconsideration. The provider shall send a copy of the application to the carrier.
(3) If, within 60 days of the provider's request for reconsideration, the provider does not receive payment for the adjusted or rejected bill or a portion of the bill, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may apply for mediation or hearing. The provider shall send the application for mediation or hearing to the agency and shall send a copy to the carrier.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101304 Disputes.
Rule 1304. (1) If a carrier adjusts or rejects a bill or a portion of a bill under these rules, then a notice given under R 418.101301(1) creates an ongoing dispute for the purpose of section 801 of the act. The time for making payment of a bill under section 801 of the act shall not run unless the bill is properly submitted according to applicable rules and statutes.
(2) Any dispute that concerns any of the following shall be resolved as if an application for mediation or hearing was filed under section 847 of the act:
(a) The medical appropriateness of health care or a health care service.
(b) Utilization of health care or a health care service.
(c) The need for health care or a health care service.
(d) Any dispute over the cost of health care or a health care service.
(3) If the dispute results in the denial of medical treatment for a worker, or if there is a petition by an employer to stop the employer's liability for medical benefits previously ordered, including proceedings under subrule (6) of this rule, then the dispute shall receive the same expedited treatment accorded to 60-day cases under section 205 of the act, except that the agency may refer the matter to mediation under section 223 of the act.
(4) A dispute under this rule may be submitted to arbitration under section 864 of the act.
(5) A dispute under this rule may be handled as a small claim under section 841(2) to (10) of the act if it meets the requirements of that section.
(6) If a carrier is required by the terms of an award to provide medical benefits, then the carrier shall continue to provide those benefits until there is a different order by any of the following entities:
(a) A magistrate.
(b) The appellate commission.
(c) The court of appeals.
(d) The supreme court.
This subrule shall not preclude the use of the maximum allowable payments provided by these rules for the payment of bills by carriers. If a carrier files an application to stop or limit its liability under this subrule, the carrier shall receive the

expedited treatment provided for under subrule (3) of this rule.
(7) If the agency believes that a provider is not in compliance with these rules, then the agency may file an application for mediation or hearing under this rule.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101305 Resolution of disputes.
Rule 1305. (1) If a carrier adjusts a fee or rejects a bill under these rules, then a notice given pursuant to R 418.101301 creates a continuing dispute for the purpose of section 801 of the act. The time for making payment of a bill under section 801 of the act shall not run unless the bill is properly submitted according to applicable rules and statutes.
(2) A magistrate, as provided under sections 315 and 847 of the act and
R 408.34 and R 408.35, shall resolve any dispute that concerns any of the following:
(a) The medical appropriateness of health care or a health care service.
(b) Utilization of health care or a health care service.
(c) The need for health care or a health care service.
(d) Any dispute over the cost of health care or a health care service.
(3) The agency may participate in any hearings that concern disputes when there is an issue that affects the provisions of these rules regarding maximum fees, medical appropriateness, or utilization of health care or health care services.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

PART 14. DATA ACQUISITION

R 418.101401 Annual medical payment report.
Rule 1401. (1) Payments for medical services received by injured workers shall be reported to the workers' compensation agency on a form prescribed by the agency entitled "Annual Medical Payment Report." The agency shall provide instruction to the carriers and service companies regarding completion of the form. The annual medical payment report shall cover the periods January 1 through December 31 and shall include all of the following information:
(a) The carrier's total number of worker's compensation cases and the total medical payments for health care services for those cases in the reporting period.
(b) Medical only cases, defined as those cases where no indemnity was paid, and the total medical payments made by the carrier for those cases.
(c) Wage loss cases, defined as those cases in which wage loss or indemnity was paid, and the total medical payments made by the carrier for those cases. For the purposes of this annual medical payment report, once wage loss benefits are paid, then the case shall always be reported as wage loss.
(2) The annual medical payment report shall be due in the agency by February 28 of each year. The report shall not include travel expenses, payments for independent medical examinations, vocational rehabilitation, or rehabilitation case management expenses.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101402 Access to workers' compensation case records.
Rule 1402. (1) The workers' compensation agency shall have access to necessary workers' compensation health care records, medical bills, and other information concerning health care or health service from workers' compensation carriers or providers.
(2) The agency may review the records and medical bills of any provider determined by a carrier to not be in compliance with the rules or to be requiring unjustified treatment, hospitalization, or office visits. If a carrier requests the agency to perform an on-site review of specific records and medical bills of a provider, then the agency shall arrange a mutually acceptable visit date with the provider, by telephone or in writing, at least 15 working days before the visit. The agency shall confirm the date of the visit in writing not less than 10 working days in advance. The agency shall, by that time, identify for the provider the records, which the agency wishes to review. The records shall remain at the provider's place of business.
(3) The workers' compensation agency shall ensure confidentiality of the individual case records regarding health care services provided to any individual.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101404 Access to carrier data for payment of medical claims.
Rule 1404. (1) The workers' compensation agency shall have access to payment data from the carrier in the form of the carrier's explanation of benefits and medical bills for the purposes of data analysis.
(2) A carrier shall be notified by the agency when information is to be submitted not less than 60 days before the date

required.
(3) The agency shall ensure confidentiality of the billing records provided by the selected carriers.
History: 2000 MR 6, Eff. May 11, 2000; 2005 MR 2, Eff. Feb. 10, 2005.

PART 15. PROCEDURE CODE AND REIMBURSEMENT TABLES

R 418.101501 Tables for health care services and procedures.
Rule 1501. (1) Procedures that do not have relative values assigned are referenced in part 15 of these rules and have assigned fees developed by the workers' compensation agency through rule promulgation and shall be published as part of these rules.
(2) The agency shall publish separate from these rules a manual containing all of the following:
(a) Procedure codes and relative value units for the medical, surgical, and radiology services.
(b) Reference to the ancillary services identified in Medicare's Level II codes as adopted by reference in R 418.10107.
(c) Maximum payment ratios for hospitals.
(d) A copy of the billing forms and instructions for completion.
History: 2000 MR 6, Eff. May 11, 2000; 2000 MR 15, Eff. Oct. 24, 2000; 2001 MR 8, Eff. May 9, 2001; 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10 2005.

R 418.101502 Miscellaneous medical and surgical procedures.
Rule 1502. The medical and surgical procedures without assigned relative values or specific payment methodologies are listed in the following table:

99000	Handling or conveyance of specimen	$5.00
99050	After hour office service Monday-Friday (R 418.10202)	$5.00
99052	Services between 10:00pm and 8:00am	$5.00
99054	Weekend, holiday after hour office service	$12.00
99199	Carrier arranged missed appointment. (R 418.10111)	BR
99199-32	Carrier or requested report, per page (R 418.10114)	$25.00
WC700	Prescription drug dispense fee (R 418.10912(4)	$4.00
99455-32	Carrier requested visit for job evaluation (R 418.10404)	$70.00
RN001-32	Rehabilitation or case manager visit (R 418.10121)	$25.00

History: 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

R 418.101503 Laboratory procedure codes and maximum allowable payments.
Rule 1503. (1) The workers' compensation agency shall determine the maximum allowable payment for the laboratory procedure codes,80048-89356 published in "Physicians' Current Procedural Terminology (CPT®)as adopted by reference in R 418.10107. The rate shall be determined by multiplying the Medicare rate established for the state of Michigan by 110%.
(2) The pathology procedure codes found in the 80000 series of procedure codes listed in CPT® as adopted by reference in R 418.10107 have assigned relative values and shall be published by the agency in a separate manual.
(3) The maximum allowable payments for the laboratory and pathology procedures shall be published the Health Care Services Manual separate from these rules.
History: 2003 MR 4, Eff. Mar. 4, 2003; 2005 MR 2, Eff. Feb. 10, 2005.

R 418. 101504
Source: 2004 AACS.

MICHIGAN JOBS COMMISSION

MICHIGAN EMPLOYMENT SECURITY AGENCY

EMPLOYMENT SECURITY

PART 1. ADMINISTRATION

R 421.1
Source: 1998-2000 AACS.

R 421.10
Source: 1980 AACS.

R 421.15
Source: 1996 AACS.

PART 2. EMPLOYERS

R 421.101
Source: 1980 AACS.

R 421.105
Source: 1980 AACS.

R 421.112
Source: 2001 AACS.

R 421.113
Source: 1998-2000 AACS.

R 421.115
Source: 1980 AACS.

R 421.121
Source: 2002 AACS.

R 421.122
Source: 2002 AACS.

R 421.123
Source: 1995 AACS.

R 421.162
Source: 2001 AACS.

R 421.184
Source: 1980 AACS.

R 421.190
Source: 2002 AACS.

PART 3. CLAIMS

R 421.201
Source: 2002 AACS.

R 421.204
Source: 2002 AACS.

R 421.205
Source: 2001 AACS.

R 421.208
Source: 2001 AACS.

R 421.209
Source: 1986 AACS.

R 421.210
Source: 2002 AACS.

R 421.211
Source: 1980 AACS.

R 421.212
Source: 1980 AACS.

R 421.215
Source: 1997 AACS.

R 421.216
Source: 2002 AACS.

R 421.243
Source: 1980 AACS.

R 421.251
Source: 1986 AACS.

R 421.269
Source: 2001 AACS.

R 421.270
Source: 2001 AACS.

R 421.301
Source: 1997 AACS.

R 421.302
Source: 1980 AACS.

SECURITY FOR REIMBURSEMENT FINANCING OF UNEMPLOYMENT INSURANCE COSTS

R 421.601
Source: 1992 AACS.

R 421.602
Source: 1992 AACS.

R 421.603
Source: 1992 AACS.

R 421.604
Source: 1992 AACS.

R 421.605
Source: 1992 AACS.

R 421.606
Source: 1992 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

EMPLOYMENT SECURITY BOARD OF REVIEW

RULES OF PRACTICE

PART 1. GENERAL PROVISIONS

R 421.1101
Source: 2002 AACS.

R 421.1103
Source: 2002 AACS.

R 421.1104
Source: 1988 AACS.

R 421.1109
Source: 1988 AACS.

R 421.1110
Source: 2002 AACS.

R 421.1111
Source: 2002 AACS.

PART 2. APPEALS TO REFEREES

R 421.1202
Source: 1988 AACS.

R 421.1203
Source: 2002 AACS.

R 421.1206
Source: 1988 AACS.

R 421.1207
Source: 1988 AACS.

R 421.1208
Source: 2002 AACS.

R 421.1211
Source: 1988 AACS.

R 421.1212
Source: 1988 AACS.

R 421.1213
Source: 1988 AACS.

R 421.1214
Source: 1988 AACS.

PART 3. APPEALS TO BOARD OF REVIEW

R 421.1302
Source: 1988 AACS.

R 421.1304
Source: 2002 AACS.

R 421.1305
Source: 2002 AACS.

R 421.1307
Source: 2002 AACS.

R 421.1309
Source: 1988 AACS.

R 421.1312
Source: 1988 AACS.

R 421.1314
Source: 1988 AACS.

R 421.1315
Source: 1988 AACS.

EMPLOYMENT RELATIONS COMMISSION

PART 1. GENERAL PROVISIONS

R 423.101
Source: 2002 AACS.

R 423.102
Source: 2002 AACS.

R 423.103
Source: 2002 AACS.

R 423.104
Source: 2002 AACS.

R 423.105
Source: 2002 AACS.

PART 2. MEDIATION OF LABOR DISPUTES

R 423.121
Source: 2002 AACS.

R 423.122
Source: 2002 AACS.

R 423.123
Source: 2002 AACS.

R 424.124
Source: 2002 AACS.

PART 3. FACT FINDING

R 423.131
Source: 2002 AACS.

R 423.132
Source: 2002 AACS.

R 423.133
Source: 2002 AACS.

R 423.134
Source: 2002 AACS.

R 423.135
Source: 2002 AACS.

R 423.136
Source: 2002 AACS.

R 423.137
Source: 2002 AACS.

R 423.138
Source: 2002 AACS.

PART 4. REPRESENTATION PROCEEDINGS

R 423.141
Source: 2002 AACS.

R 423.142
Source: 2002 AACS.

R 423.143
Source: 2002 AACS.

R 423.144
Source: 2002 AACS.

R 423.145
Source: 2002 AACS.

R 423.146
Source: 2002 AACS.

R 423.147
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R 423.148
Source: 2002 AACS.

R 423.149
Source: 2002 AACS.

R 423.149a
Source: 2002 AACS.

R 423.149b
Source: 2002 AACS.

PART 5. UNFAIR LABOR PRACTICE CHARGES

R 423.151
Source: 2002 AACS.

R 423.152
Source: 2002 AACS.

R 423.153
Source: 2002 AACS.

R 423.154
Source: 2002 AACS.

R 423.155
Source: 2002 AACS.

R 423.156
Source: 2002 AACS.

R 423.157
Source: 2002 AACS.

R 423.158
Source: 2002 AACS.

PART 6. MOTION PRACTICE

R 423.161
Source: 2002 AACS.

R 423.162
Source: 2002 AACS.

R 423.163
Source: 2002 AACS.

R 423.164
Source: 2002 AACS.

R 423.165
Source: 2002 AACS.

R 423.166
Source: 2002 AACS.

R 423.167
Source: 2002 AACS.

PART 7. HEARINGS

R 423.171
Source: 2002 AACS.

R 423.172
Source: 2002 AACS.

R 423.173
Source: 2002 AACS.

R 423.174
Source: 2002 AACS.

R 423.175
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R 423.176
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R 423.177
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R 423.178
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R 423.179
Source: 2002 AACS.

PART 8. FILING AND SERVICE OF DOCUMENTS

R 423.181
Source: 2002 AACS.

R 423.182
Source: 2002 AACS.

R 423.183
Source: 2002 AACS.

R 423.184
Source: 2002 AACS.

PART 9. NOTICE OF PUBLIC SCHOOL STRIKE OR LOCKOUT

R 423.191
Source: 2002 AACS.

R 423.192
Source: 2002 AACS.

R 423.193
Source: 2002 AACS.

R 423.194
Source: 2002 AACS.

R 423.301
Source: 1997 AACS.

R 423.302
Source: 1997 AACS.

R 423.303
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R 423.304
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R 423.305
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R 423.306
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R 423.315
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R 423.316
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R 423.317
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R 423.401
Source: 2002 AACS.

R 423.403
Source: 2002 AACS.

R 423.405
Source: 2002 AACS.

R 423.407
Source: 2002 AACS.

R 423.411
Source: 2002 AACS.

R 423.421
Source: 2002 AACS.

R 423.422
Source: 2002 AACS.

R 423.423
Source: 2002 AACS.

R 423.431
Source: 2002 AACS.

R 423.432
Source: 2002 AACS.

R 423.433
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R 423.434
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R 423.435
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R 423.451
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R 423.453
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R 423.461
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R 423.469
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R 423.470
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R 423.471
Source: 2002 AACS.

R 423.472
Source: 2002 AACS.

R 423.481
Source: 2002 AACS.

R 423.482
Source: 2002 AACS.

R 423.483
Source: 2002 AACS.

R 423.484
Source: 2002 AACS.

ADMINISTRATION OF COMPULSORY ARBITRATION ACT FOR LABOR DISPUTES IN MUNICIPAL

POLICE AND FIRE DEPARTMENTS

R 423.501
Source: 1995 AACS.

R 423.502
Source: 1995 AACS.

R 423.503
Source: 1995 AACS.

R 423.504
Source: 1995 AACS.

R 423.505
Source: 1995 AACS.

R 423.506
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R 423.507
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R 423.511
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R 423.512
Source: 1995 AACS.

R 423.513
Source: 1995 AACS.

R 423.514
Source: 1995 AACS.

DEPARTMENT OF AGRICULTURE

RACING COMMISSIONER

GENERAL RULES

R 431.1
Source: 1997 AACS.

R 431.2
Source: 1997 AACS.

R 431.3
Source: 1997 AACS.

R 431.4
Source: 1997 AACS.

R 431.5
Source: 1997 AACS.

R 431.6
Source: 1997 AACS.

R 431.7
Source: 1997 AACS.

R 431.8
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R 431.10
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R 431.11
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R 431.42
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R 431.44
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R 431.45
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R 431.46
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R 431.47
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R 431.50
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R 431.51
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R 431.61
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R 431.62
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R 431.63
Source: 1997 AACS.

R 431.64
Source: 1997 AACS.

R 431.65
Source: 1997 AACS.

R 431.66
Source: 1997 AACS.

R 431.67
Source: 1997 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

ATHLETIC BOARD OF CONTROL

GENERAL RULES

R 431.101
Source: 1997 AACS.

R 431.102
Source: 1997 AACS.

R 431.103
Source: 1997 AACS.

R 431.104
Source: 1997 AACS.

R 431.105
Source: 1997 AACS.

R 431.106
Source: 1997 AACS.

R 431.107
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R 431.108
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R 431.109

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R 431.110
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R 431.111
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R 431.112
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R 431.113
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R 431.114
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R 431.115
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R 431.116
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R 431.118
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R 431.119
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R 431.120
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R 431.121
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R 431.122
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R 431.123
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R 431.124
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R 431.125
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R 431.126
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R 431.127
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R 431.128
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R 431.129
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R 431.130
Source: 1997 AACS.

R 431.131
Source: 1997 AACS.

R 431.132
Source: 1997 AACS.

R 431.133
Source: 1997 AACS.

DIRECTOR'S OFFICE

ATHLETICS

R 431.141
Source: 1997 AACS.

R 431.142
Source: 1997 AACS.

R 431.143
Source: 1997 AACS.

R 431.144
Source: 1997 AACS.

R 431.145
Source: 1997 AACS.

R 431.146
Source: 1997 AACS.

R 431.147
Source: 1997 AACS.

DEPARTMENT OF AGRICULTURE

RACING COMMISSIONER

GENERAL RULES

PART 1. GENERAL PROVISIONS

R 431.1001
Source: 1991 AACS.

R 431.1005
Source: 1985 AACS.

R 431.1010
Source: 1985 AACS.

R 431.1015

Source: 1985 AACS.

R 431.1020
Source: 1985 AACS.

R 431.1025
Source: 1985 AACS.

R 431.1027
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R 431.1030
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R 431.1035
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R 431.1045
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R 431.1050
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R 431.1055
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R 431.1060
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R 431.1065
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R 431.1070
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R 431.1075
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R 431.1080
Source: 1985 AACS.

R 431.1085
Source: 1985 AACS.

R 431.1090
Source: 1985 AACS.

R 431.1095
Source: 1985 AACS.

R 431.1101
Source: 1985 AACS.

R 431.1105
Source: 1985 AACS.

R 431.1110
Source: 1985 AACS.

R 431.1115
Source: 1985 AACS.

R 431.1120
Source: 1985 AACS.

R 431.1125
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R 431.1130
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R 431.1135
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R 431.1180
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R 431.1185
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R 431.1190
Source: 1985 AACS.

R 431.1195
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R 431.1200
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R 431.1205
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R 431.1210
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R 431.1215
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R 431.1290
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R 431.1295
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R 431.1301
Source: 1991 AACS.

R 431.1325
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R 431.1330
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R 431.1335
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R 431.1340
Source: 1985 AACS.

R 431.1999
Source: 1985 AACS.

PART 2. MUTUELS

R 431.2001
Source: 1985 AACS.

R 431.2005
Source: 1985 AACS.

R 431.2010
Source: 1985 AACS.

R 431.2015
Source: 1985 AACS.

R 431.2020
Source: 1985 AACS.

R 431.2025
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R 431.2030
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R 431.2035
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R 431.2040
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R 431.2055
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R 431.2060
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R 431. 2061
Source: 2003 AACS.

R 431.2065
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R 431.2070
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R 431.2075
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R 431.2080
Source: 1985 AACS.

R 431.2085
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R 431.2090
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R 431.2095
Source: 1985 AACS.

R 431.2100
Source: 1985 AACS.

R 431.2105
Source: 1985 AACS.

R 431.2110
Source: 1985 AACS.

R 431.2115
Source: 1985 AACS.

R 431.2120
Source: 1985 AACS.

PART 3. THOROUGHBRED RACING

R 431.3001
Source: 1985 AACS.

R 431.3005
Source: 1985 AACS.

R 431.3010
Source: 1985 AACS.

R 431.3015
Source: 1985 AACS.

R 431.3020
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R 431.3025
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R 431.3030
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R 431.3095
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R 431.3101
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R 431.3105
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R 431.3110
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R 431.3115
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R 431.3120
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R 431.3125
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R 431.3130
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R 431.3135
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R 431.3140
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R 431.3145
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R 431.3150
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R 431.3175
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R 431.3180
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R 431.3195
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R 431.3201
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R 431.3205
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R 431.3215
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R 431.3245
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R 431.3250
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R 431.3260
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R 431.3270
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R 431.3290
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R 431.3295
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R 431.3301
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R 431.3305
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R 431.3310
Source: 1989 AACS.

PART 4. HARNESS RACING

R 431.4001
Source: 1985 AACS.

R 431.4005
Source: 1985 AACS.

R 431.4010
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R 431.4015
Source: 1985 AACS.

R 431.4020
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R 431.4025
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R 431.4075
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R 431.4080
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R 431.4085
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R 431.4090
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R 431.4095
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R 431.4100
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R 431.4105
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R 431.4110
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R 431.4115
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R 431.4120
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R 431.4125
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R 431.4130
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R 431.4135
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R 431.4140
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R 431.4145
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R 431.4150
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R 431.4160
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R 431.4180
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R 431.4185
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R 431.4190
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R 431.4195
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R 431.4200
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R 431.4205
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R 431.4210
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R 431.4215
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R 431.4220
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R 431.4225
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R 431.4230
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R 431.4235
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R 431.4240
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R 431.4245
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R 431.4250
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R 431.4255
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R 431.4260
Source: 1985 AACS.

R 431.4265
Source: 1985 AACS.

R 431.4270
Source: 1985 AACS.

R 431.4275
Source: 1985 AACS.

R 431.4280
Source: 1985 AACS.

R 431.4285
Source: 1985 AACS.

R 431.4290
Source: 1985 AACS.

DEPARTMENT OF TREASURY

BUREAU OF STATE LOTTERY

LOTTERY RULES

PART 1. GENERAL PROVISIONS

R 432.1
Source: 1998-2000 AACS.

R 432.2
Source: 1998-2000 AACS.

R 432.4
Source: 1998-2000 AACS.

R 432.5
Source: 2001 AACS.

R 432.6
Source: 2001 AACS.

R 432.7
Source: 1998-2000 AACS.

R 432.8
Source: 1998-2000 AACS.

R 432.12
Source: 1998-2000 AACS.

R 432.13
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R 432.14
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R 432.15
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R 432.16
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R 432.17
Source: 2001 AACS.

R 432.18
Source: 1998-2000 AACS.

R 432.19
Source: 1998-2000 AACS.

R 432.20
Source: 1998-2000 AACS.

R 432.22
Source: 1998-2000 AACS.

PART 2. ON-LINE TERMINALS

R 432.31
Source: 1998-2000 AACS.

R 432.32
Source: 1998-2000 AACS.

R 432.33
Source: 1998-2000 AACS.

R 432.34
Source: 1998-2000 AACS.

R 432.35
Source: 1998-2000 AACS.

R 432.36
Source: 1998-2000 AACS.

R 432.37
Source: 2001 AACS.

R 432.38
Source: 1986 AACS.

BINGO RULES

R 432.101
Source: 1998-2000 AACS.

R 432.102
Source: 1998-2000 AACS.

R 432.103
Source: 1998-2000 AACS.

R 432.104
Source: 1998-2000 AACS.

R 432.105
Source: 1998-2000 AACS.

R 432.106
Source: 1998-2000 AACS.

R 432.107
Source: 1998-2000 AACS.

R 432.108
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R 432.109
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R 432.110
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R 432.111
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R 432.112
Source: 1998-2000 AACS.

R 432.113
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R 432.114
Source: 1998-2000 AACS.

R 432.115
Source: 1998-2000 AACS.

R 432.116
Source: 1998-2000 AACS.

R 432.117
Source: 1998-2000 AACS.

R 432.118
Source: 1998-2000 AACS.

MILLIONAIRE PARTY RULES

R 432.201
Source: 1998-2000 AACS.

R 432.202
Source: 1998-2000 AACS.

R 432.203
Source: 1998-2000 AACS.

R 432.204
Source: 1998-2000 AACS.

R 432.205
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R 432.206
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R 432.207
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R 432.208
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R 432.209
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R 432.210
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R 432.211
Source: 1998-2000 AACS.

R 432.212
Source: 1998-2000 AACS.

R 432.212a
Source: 1998-2000 AACS.

R 432.213
Source: 1998-2000 AACS.

R 432.214
Source: 1998-2000 AACS.

R 432.215
Source: 1998-2000 AACS.

R 432.216
Source: 1998-2000 AACS.

CHARITY GAMES

R 432.301
Source: 1983 AACS.

R 432.302
Source: 1983 AACS.

R 432.303
Source: 1983 AACS.

R 432.304
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R 432.305
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R 432.306
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R 432.307
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R 432.308
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R 432.309
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R 432.310
Source: 1983 AACS.

R 432.311
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R 432.312
Source: 1983 AACS.

R 432.313
Source: 1983 AACS.

CRANE GAMES

R 432.401
Source: 1998-2000 AACS.

R 432.402
Source: 1998-2000 AACS.

R 432.403
Source: 1998-2000 AACS.

R 432.404
Source: 1998-2000 AACS.

R 432.405
Source: 1998-2000 AACS.

R 432.406
Source: 1998-2000 AACS.

R 432.407
Source: 1998-2000 AACS.

R 432.408
Source: 1998-2000 AACS.

R 432.409
Source: 1998-2000 AACS.

DEPARTMENT OF STATE

BUREAU OF ELECTIONS

CASINO INTEREST REGISTRATION

R 432.1001
Source: 1998-2000 AACS.

R 432.1002
Source: 1998-2000 AACS.

R 432.1003
Source: 1998-2000 AACS.

DEPARTMENT OF TREASURY

MICHIGAN GAMING CONTROL BOARD

CASINO GAMING

PART 1. DEFINITIONS

R 432.1101
Source: 1998-2000 AACS.

R 432.1102
Source: 1998-2000 AACS.

R 432.1103
Source: 1998-2000 AACS.

R 432.1104
Source: 1998-2000 AACS.

R 432.1105
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R 432.1106
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R 432.1107
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R 432.1108
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R 432.1109
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PART 2. GENERAL PROVISIONS

R 432.1201
Source: 1998-2000 AACS.

R 432.1202
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R 432.1203
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R 432.1204
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PART 3. LICENSES

R 432.1301
Source: 1998-2000 AACS.

R 432.1302
Source: 1998-2000 AACS.

R 432.1303
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R 432.1304
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R 432.1340
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R 432.1341
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PART 4. PUBLIC OFFERING OF DEBT OR EQUITY FOR MICHIGAN CASINOS

R 432.1401
Source: 1998-2000 AACS.

R 432.1402
Source: 1998-2000 AACS.

R 432.1403
Source: 1998-2000 AACS.

R 432.1404
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R 432.1405
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R 432.1406
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R 432.1407
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PART 5. TRANSFER OF OWNERSHIP

R 432.1501
Source: 1998-2000 AACS.

R 432.1502
Source: 1998-2000 AACS.

R 432.1503
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R 432.1504
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PART 6. EXCLUSION OF PERSONS

R 432.1601
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R 432.1602
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R 432.1603
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R 432.1604
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R 432.1605
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PART 7. DENIAL AND EXCLUSION HEARINGS

R 432.1701
Source: 1998-2000 AACS.

R 432.1702
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R 432.1703
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R 432.1704
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PART 8. CONDUCT OF GAMING

R 432.1801
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R 432.1802
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R 432.1803
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R 432.1843
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PART 9. INTERNAL CONTROL PROCEDURES

R 432.1901
Source: 1998-2000 AACS.

R 432.1902
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R 432.1903
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R 432.1904
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R 432.1905
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R 432.1906
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PART 10. SECURITY AND SURVEILLANCE

R 432.11001
Source: 1998-2000 AACS.

R 432.11002
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R 432.11003
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R 432.11004
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R 432.11016
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R 432.11017
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R 432.11018
Source: 1998-2000 AACS.

PART 11. SEIZURE, FORFEITURE AND DISCIPLINARY HEARINGS

R 432.11101
Source: 1998-2000 AACS.

R 432.11102
Source: 1998-2000 AACS.

R 432.11103
Source: 1998-2000 AACS.

R 432.11104
Source: 1998-2000 AACS.

R 432.11105
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R 432.11106
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R 432.11107
Source: 1998-2000 AACS.

R 432.11108
Source: 1998-2000 AACS.

R 432.11109
Source: 1998-2000 AACS.

PART 12. ACCOUNTING RECORDS AND PROCEDURES

R 432.11201
Source: 1998-2000 AACS.

R 432.11202
Source: 1998-2000 AACS.

R 432.11203
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R 432.11204
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R 432.11208
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R 432.11209
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PART 13. CREDIT

R 432.11301
Source: 1998-2000 AACS.

R 432.11302
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R 432.11303
Source: 1998-2000 AACS.

R 432.11304
Source: 1998-2000 AACS.

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R 432.11306
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R 432.11308
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R 432.11309
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R 432.11311
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R 432.11312
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PART 14. MOVEMENT OF GAMING EQUIPMENT

R 432.11401
Source: 1998-2000 AACS.

R 432.11402
Source: 1998-2000 AACS.

R 432.11403
Source: 1998-2000 AACS.

R 432.11404
Source: 1998-2000 AACS.

R 432.11405
Source: 1998-2000 AACS.

R 432.11406
Source: 1998-2000 AACS.

PART 15. DISPUTE PROCEDURES

R 432.11501
Source: 1998-2000 AACS.

R 432.11502
Source: 1998-2000 AACS.

R 432.11503
Source: 1998-2000 AACS.

DEPARTMENT OF TREASURY

BUREAU OF STATE LOTTERY

CHARITABLE GAMING DIVISION

PART 1. GENERAL

R 432.21101
Source: 2003 AACS.

R 432.21102
Source: 1998-2000 AACS.

R 432.21103
Source: 1998-2000 AACS.

R 432.21104
Source: 1998-2000 AACS.

R 432.21105
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R 432.21106
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R 432.21107
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R 432.21108
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R 432.21109
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R 432.21110
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R 432.21111
Source: 1998-2000 AACS.

R 432.21112
Source: 1998-2000 AACS.

R 432.21113
Source: 1998-2000 AACS.

R 432.21199
Source: 1998-2000 AACS.

PART 2. GAMING LICENSING

R 432.21201
Source: 2003 AACS.

R 432.21202
Source: 2003 AACS.

R 432.21203
Source: 1998-2000 AACS.

R 432.21204
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R 432.21207
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R 432.21208
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PART 3. BINGO

R 432.21301
Source: 2003 AACS.

R 432.21302
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R 432.21303
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R 432.21336
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PART 4. MILLIONAIRE PARTY

R 432.21401
Source: 1998-2000 AACS.

R 432.21402
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R 432.21403
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R 432.21404
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R 432.21419
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PART 5. RAFFLE

R 432.21501
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R 432.21502
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R 432.21521
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R 432.21522
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PART 6. CHARITY GAME

R 432.21601
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R 432.21602
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R 432.21603
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PART 7. NUMERAL GAME

R 432.21701
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R 432.21721
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PART 8. SUPPLIER

R 432.21801
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R 432.21803

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R 432.21813
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PART 9. MANUFACTURER

R 432.21901
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R 432.21902
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Part 10. Hall

R 432.22001
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R 432.22002
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R 432.22003
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R 432.22004
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R 432.22006
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R 432.22007
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R 432.22008
Source: 2003 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

LIQUOR CONTROL COMMISSION

RETAIL LICENSEES SELLING ALCOHOLIC BEVERAGES FOR CONSUMPTION ON PREMISES

R 436.1
Source: 1997 AACS.

R 436.2
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R 436.3
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R 436.4
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R 436.16
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R 436.18
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R 436.19
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R 436.19(1)
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R 436.20
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R 436.21
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R 436.40
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R 436.41
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RETAIL SALE OF BEER AND WINE FOR CONSUMPTION OFF PREMISES

R 436.51
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R 436.52
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R 436.64
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R 436.66
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R 436.67
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R 436.67(1)
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R 436.67(2)
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R 436.80
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R 436.81
Source: 1997 AACS.

SPECIALLY DESIGNATED DISTRIBUTORS SELLING SPIRITS FOR CONSUMPTION OFF PREMISES

R 436.91
Source: 1997 AACS.

R 436.92
Source: 1997 AACS.

R 436.93
Source: 1997 AACS.

R 436.94
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R 436.123
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R 436.124
Source: 1997 AACS.

LICENSED MANUFACTURERS, WHOLESALERS, SALES REPRESENTATIVES, AND RETAIL LICENSEES

R 436.544
Source: 1997 AACS.

SPECIAL LICENSES FOR SALE OF ALCOHOLIC LIQUOR AT RETAIL FOR CONSUMPTION ON PREMISES

R 436.571
Source: 1998-2000 AACS.

R 436.572
Source: 1998-2000 AACS.

R 436.573
Source: 1998-2000 AACS.

R 436.574
Source: 1998-2000 AACS.

R 436.575
Source: 1998-2000 AACS.

R 436.578
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R 436.580
Source: 1998-2000 AACS.

R 436.581
Source: 1998-2000 AACS.

R 436.582
Source: 1998-2000 AACS.

PURCHASES OF ALCOHOLIC SPIRITS BY HOSPITALS, CHARITABLE INSTITUTIONS, AND MILITARY ESTABLISHMENTS WITHIN STATE

R 436.601
Source: 1997 AACS.

GENERAL RULES

R 436.1001
Source: 2003 AACS.

R 436.1003
Source: 1980 AACS.

R 436.1005
Source: 1980 AACS.

R 436.1007
Source: 1980 AACS.

R 436.1009
Source: 1980 AACS.

R 436.1011
Source: 2003 AACS.

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Source: 1980 AACS.

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Source: 1980 AACS.

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Source: 1980 AACS.

R 436.1023
Source: 1998-2000 AACS.

R 436.1025
Source: 1980 AACS.

R 436.1027
Source: 1980 AACS.

R 436.1129 Specially designated merchant license; issuance and transfer; limitation; waiver; applicability.
Rule 29. (1) For the issuance of a new, or the transfer of location of an existing, specially designated merchant license, all of the following are approved types of businesses:
(a) A grocery store.
(b) A convenience food store.
(c) A food specialty store.
(d) A meat market.
(e) A delicatessen.
(f) A drugstore.
(g) A patent medicine store.
(h) A tobacconist that is in compliance with subrule (3)(e) of this rule.
(i) A department store that includes 1 or more of the stores listed in subdivisions (a) to (h) of this subrule.
(j) A specially designated distributor.
(k) A class C.
(l) A class B hotel.
(m) A club.
(n) A tavern.
(o) A class A hotel licensed establishment.
(2) The commission shall not issue a new, or transfer location of an existing, specially designated merchant license to an

applicant operating an approved type of business who also holds, or a partner or stockholder of an applicant who holds, an interest, directly or indirectly, in a nonapproved type of business on, or contiguous to, the proposed licensed premises, unless 60% or more of the combined monthly gross sales of the approved and nonapproved businesses are of goods and services customarily marketed by the approved type of business. For the purposes of this subrule, combined monthly gross sales are sales exclusive of all taxes collected by a retailer on sales and are computed for an accounting period of not less than 180 consecutive days. The commission may approve an application under this rule subject to the condition that the applicant shall demonstrate compliance with this subrule at the end of the 180-day accounting period. The commission shall cancel the license if the licensee has failed to comply with the provisions of this subrule at the end of the 180-day accounting period.

(3) The commission shall not issue a specially designated merchant license to any of the following entities and shall not allow any of the following entities to change the nature of an existing business that has a specially designated merchant license:

(a) An applicant who owns motor vehicle fuel pumps which are at the same location as, which are operated in conjunction with, or which are a part of, the proposed licensed business.

(b) An applicant who holds any financial interest, directly or indirectly, in the establishment, maintenance, operation, or promotion of the sale of motor vehicle fuel at the proposed location of, in conjunction with, or as a part of, the proposed licensed business.

(c) An applicant who holds any interest, directly or indirectly, by ownership in fee, leasehold, mortgage, or otherwise, in the establishment, maintenance, operation, or promotion of the sale of motor vehicle fuel at the proposed location of, in conjunction with, or as a part of, the proposed licensed business.

(d) An applicant who holds any interest, directly or indirectly, through interlocking stock ownership in a corporation or through interlocking directors in a corporation engaged in the establishment, maintenance, operation, or promotion of the sale of motor vehicle fuel at the proposed location of, in conjunction with, or as a part of, the proposed licensed business.

(e) An applicant at any location at which motor vehicle fuel is sold or offered for sale by any person, whether or not the applicant has any interest or derives any profit from the sale.

(4) In determining the qualifications of an applicant for or the holder of a specially designated merchant license to own or operate motor vehicle fuel pumps on or adjacent to the licensed premises under the provisions of section 541(1) of 1998 PA 58, MCL 436.1541(1), the following shall apply:

(a) The minimum inventory required shall exclude alcoholic liquor, motor vehicle fuel, and any merchandise acquired on a consignment basis and not less than 60% of this inventory shall consist of goods and services which, in themselves, would qualify the applicant or licensee for licensure under subrule (1) of this rule.

(b) In the case of a department store, as defined in R 436.1001(e), the inventory attributable to that department which qualifies the business for licensure shall consist of not less than 60% of goods and services which, in themselves, would qualify the business for licensure under subrule (1) of this rule.

(c) The distance between the motor vehicle fuel pumps and the site of payment and selection of alcoholic liquor shall be determined by measuring from the motor vehicle fuel pump nearest the licensed premises to that part of the licensed premises nearest the motor vehicle fuel pumps.

(5) In a city, incorporated village, or township that has a population of 3,000 or fewer people, the commission may, in its discretion, waive the provisions of subrules (1), (2), and (3) of this rule if the applicant for a license has and maintains a minimum inventory on the premises, excluding alcoholic liquor, of not less than $10,000.00, at cost, of the goods and services customarily marketed by approved types of businesses. The commission shall accept the means prescribed in R 436.1141(1) as a method for determining the population of a city, incorporated village, or township.

(6) In a township which is comprised of 72 square miles or more and which has a population of 7,500 or fewer people, the commission may, in its discretion, waive the provisions of subrule (3) of this rule if the applicant for a license has and maintains a minimum inventory on the premises, excluding alcoholic liquor, of not less than $10,000.00, at cost, of the goods and services customarily marketed by approved types of businesses.

(7) The commission shall not issue a specially designated merchant license to an applicant who operates a drive-in or drive-through establishment and shall not allow an applicant who operates a drive-in or drive-through establishment to change the nature of an existing business that has a specially designated merchant license.

(8) The commission shall not issue a specially designated merchant license to an applicant who operates a drive-up or walk-up window for the sale of alcoholic liquor at the proposed location and shall not allow a person who holds a specially designated merchant license to change the nature of the existing licensed business to include a drive-up or walk-up window which permits the sale of alcoholic liquor through the drive-up or walk-up window.

(9) This rule does not apply to the renewal of an existing specially designated merchant license that is in operation before the effective date of this rule and does not apply to a new specially designated merchant license or the transfer of location of a specially designated merchant license conditionally approved by the commission before the effective date of this rule.

History: 1954 ACS 94, Eff. Mar. 15, 1978; 1954 ACS 96, Eff. June 23, 1978; 1979 AC; 1985 MR 2, Eff. Mar. 1, 1985;

1985 MR 5, Eff. June 18, 1985; 2000 MR 3, Eff. Mar. 20, 2000; 2004 MR 6, Eff. Mar. 24, 2004; 2005 MR 23, Eff. Dec. 12, 2005.

R 436.1031
Source: 1980 AACS.

R 436.1033
Source: 1980 AACS.

R 436.1135 Specially designated distributor license; limitations upon issuance or transfer; waiver; applicability.
Rule 35. (1) For the issuance of a new, or the transfer of location of an existing, specially designated distributor license, all of the following are approved types of businesses:
(a) A grocery store.
(b) A convenience food store.
(c) A food specialty store.
(d) A meat market.
(e) A delicatessen.
(f) A drugstore.
(g) A patent medicine store.
(h) A tobacconist that is in compliance with subrule (3)(e) of this rule.
(i) A department store that includes 1 or more of the stores listed in subdivisions (a) to (h) of this subrule.
(j) A hotel.
(2) The commission shall not issue a new, or transfer location of an existing, specially designated distributor license to an applicant operating an approved type of business who also holds, or a partner or stockholder of the applicant who holds, an interest, directly or indirectly, in a nonapproved type of business on, or contiguous to, the proposed licensed premises, unless 60% or more of the combined monthly gross sales of the approved and nonapproved businesses are of goods and services customarily marketed by the approved type of business. For the purposes of this subrule, combined monthly gross sales are exclusive of all taxes collected by a retailer on sales and are computed for an accounting period of not less than 180 consecutive days. The commission may approve an application under this rule subject to the condition that the applicant shall demonstrate compliance with this subrule at the end of the 180-day accounting period. The commission shall cancel the license if the licensee has failed to comply with the provisions of this subrule at the end of the 180-day accounting period.
(3) The commission shall not issue a specially designated distributor license to any of the following entities and shall not allow any of the following entities to change the nature of an existing business that has a specially designated distributor license:
(a) An applicant who owns motor vehicle fuel pumps which are at the same location as, which are operated in conjunction with, or which are a part of, the proposed licensed business.
(b) An applicant who holds any financial interest, directly or indirectly, in the establishment, maintenance, operation, or promotion of the sale of motor vehicle fuel at the proposed location of, in conjunction with, or as a part of, the proposed licensed business.
(c) An applicant who holds any interest, directly or indirectly, by ownership in fee, leasehold, mortgage, or otherwise, in the establishment, maintenance, operation, or promotion of the sale of motor vehicle fuel at the proposed location of, or in conjunction with, or as a part of, the proposed licensed business.
(d) An applicant who holds any interest, directly or indirectly, through interlocking stock ownership in a corporation or through interlocking directors in a corporation engaged in the establishment, maintenance, operation, or promotion of the sale of motor vehicle fuel at the proposed location of, in conjunction with, or as a part of, the proposed licensed business.
(e) An applicant at any location at which motor vehicle fuel is sold or offered for sale by any person, whether or not the applicant has any interest or derives any profit from the sale.
(4) In determining the qualifications of an applicant for or the holder of a specially designated distributor license to own or operate motor vehicle fuel pumps on or adjacent to the licensed premises under the provisions of section 541(1) of 1998 PA 58, MCL 436.1541(1), the following shall apply:
(a) The minimum inventory required shall exclude alcoholic liquor, motor vehicle fuel, and any merchandise acquired on a consignment basis and not less than 60% of this inventory shall consist of goods and services which, in themselves, would qualify the applicant or licensee for licensure under subrule (1) of this rule.
(b) In the case of a department store, as defined in R 436.1001(e), the inventory attributable to that department which qualifies the business for licensure shall consist of not less than 60% of goods and services which, in themselves, would qualify the business for licensure under subrule (1) of this rule.

(c) The distance between the motor vehicle fuel pumps and the site of payment and selection of alcoholic liquor shall be determined by measuring from the motor vehicle fuel pump nearest the licensed premises to that part of the licensed premises nearest the motor vehicle fuel pumps.
(5) In a city, incorporated village, or township that has a population of 3,000 or fewer people, the commission may, in its discretion, waive the provisions of subrules (1), (2) and (3) of this rule if the applicant for a license has and maintains a minimum inventory on the premises, excluding alcoholic liquor, of not less than $12,500.00, at cost, of the goods and services customarily marketed by approved types of businesses. The commission shall accept the means prescribed in R 436.1141(1) as a method for determining the population of a city, incorporated village, or township.
(6) In a township which is comprised of 72 square miles or more and which has a population of 7,500 or fewer people, the commission may waive the provisions of subrule (3) of this rule if the applicant for a license has and maintains a minimum inventory on the premises, excluding alcoholic liquor, of not less than $12,500.00, at cost, of the goods and services customarily marketed by approved types of businesses. The commission shall accept the means prescribed in R 436.1141(1) as the method for determining the population of a township.
(7) Subrules (1), (2), (3), (4), (5), and (10) of this rule do not apply to the renewal of an existing specially designated distributor license in operation before the effective date of this rule and do not apply to a new specially designated distributor license or the transfer of location of a specially designated distributor license conditionally approved by the commission before the effective date of this rule.
(8) The commission shall not approve the transfer of location of a specially designated distributor license outside the governmental unit for which it was issued, except upon a showing of good cause by the applicant.
(9) Upon a showing of good cause by the applicant, the commission may waive the quota restrictions of R 436.1141 if all of the following conditions are met:
(a) The applicant is in a city, incorporated village, or township that has a population of 3,000 or fewer people. The commission shall accept the means prescribed in R 436.1141(1) as a method for determining the population of a city, incorporated village, or township.
(b) The only existing specially designated distributor license is held in conjunction with a class A or class B hotel license.
(c) The commission may grant only 1 waiver of quota restrictions in a city, incorporated village, or township.
(10) The commission shall not issue a specially designated distributor license to an applicant who operates a drive-in or drive-through establishment and shall not allow the applicant to change the nature of an existing business that has a specially designated distributor license.
(11) The commission shall not issue a specially designated distributor license to an applicant who operates a drive-up or walk-up window for the sale of alcoholic liquor at the proposed location and shall not allow a person who holds a specially designated distributor license to change the nature of the existing licensed business to include a drive-up or walk-up window which permits the sale of alcoholic liquor through the drive-up or walk-up window.
History: 1954 ACS 94, Eff. Mar. 15, 1978; 1954 ACS 96,Eff.June 23, 1978; 1979 AC; 1985 MR 2, Eff. Mar. 1, 1985; 1985 MR 5,Eff.June 18, 1985; 2000 MR 3, Eff. Mar. 20, 2000; 2004 MR 6, Eff. Mar. 24, 2004; 2005 MR 23, Eff. Dec. 12, 2005.

R 436.1037
Source: 2003 AACS.

R 436.1039
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R 436.1041
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R 436.1043
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R 436.1045
Source: 1998-2000 AACS.

R 436.1047
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R 436.1049
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R 436.1051
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R 436.1053
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R 436.1055
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R 436.1057
Source: **2004 AACS.**

R 436.1059
Source: 1998-2000 AACS.

R 436.1060
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R 436.1061
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R 436.1062
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R 436.1063
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LICENSING QUALIFICATIONS

R 436.1101
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R 436.1105
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R 436.1107
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R 436.1109
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R 436.1110
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R 436.1113
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R 436.1115
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R 436.1117
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R 436.1119
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R 436.1121
Source: 1998-2000 AACS.

R 436.1123
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R 436.1125
Source: 1985 AACS.

R 436.1129
Source: 2004 AACS.

R 436.1131
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R 436.1151
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SPECIAL PERMITS FOR HOSPITALS AND INSTITUTIONS

R 436.1251
Source: 1981 AACS.

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R 436.1301
Source: 1997 AACS.

R 436.1309
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R 436.1313
Source: 1998-2000 AACS.

R 436.1315
Source: 1989 AACS.

R 436.1317
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R 436.1329
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ON-PREMISES LICENSES

R 436.1401
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R 436.1403
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R 436.1405
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R 436.1407
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OFF-PREMISES LICENSES

R 436.1501
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R 436.1503
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R 436.1802
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R 436.1851
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R 436.1901
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R 436.2019
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R 436.2021
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DEPARTMENT OF STATE

BUREAU OF DRIVER AND VEHICLE RECORDS

EXPEDITING REGULAR SEARCH PROCESS

R 440.1
Source: 2002 AACS.

R 440.2
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R 440.3
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R 440.4
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R 440.5
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R 440.6
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PART 1. GENERAL PROVISIONS

R 440.101
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R 440.102
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PART 2. ACCEPTANCE AND REFUSAL OF DOCUMENTS

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R 440.202
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PART 3. UCC INFORMATION MANAGEMENT SYSTEM

R 440.301
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PART 4. FILING AND DATA ENTRY PROCEDURES

R 440.401
Source: 2002 AACS.

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PART 5. SEARCH REQUESTS AND REPORTS

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Source: 1995 AACS.

R 445.1037
Source: 1995 AACS.

R 445.1038
Source: 1997 AACS.

DEPARTMENT OF TREASURY

REVENUE DIVISION

CORPORATION TAX APPEAL BOARD

PRACTICE AND PROCEDURE

R 450.51
Source: 1997 AACS.

R 450.52
Source: 1997 AACS.

R 450.53
Source: 1997 AACS.

R 450.54
Source: 1997 AACS.

R 450.55
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R 450.56
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R 450.60
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R 450.64
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R 450.65
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R 450.66
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R 450.67
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R 450.68
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R 450.69
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R 450.70
Source: 1997 AACS.

R 450.71
Source: 1997 AACS.

R 450.72
Source: 1997 AACS.

R 450.73
Source: 1997 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

MANUFACTURING DEVELOPMENT GROUP

EMPLOYEE-OWNED CORPORATION REVOLVING LOAN FUND

R 450.801
Source: 1987 AACS.

R 450.802
Source: 1987 AACS.

R 450.803
Source: 1987 AACS.

R 450.804
Source: 1987 AACS.

R 450.805
Source: 1987 AACS.

R 450.806
Source: 1987 AACS.

R 450.807
Source: 1987 AACS.

R 450.808
Source: 1987 AACS.

R 450.809
Source: 1987 AACS.

R 450.810
Source: 1987 AACS.

OFFICE OF DIRECTOR

RESIDENTIAL BUILDING CONTRACTORS' DIVISION

R 451.501
Source: 1997 AACS.

R 451.502
Source: 1997 AACS.

R 451.503
Source: 1997 AACS.

R 451.504
Source: 1997 AACS.

R 451.505
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R 451.506
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R 451.507
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R 451.508
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R 451.509
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R 451.510
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R 451.511
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R 451.512
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R 451.513
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R 451.514
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R 451.518
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R 451.522
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R 451.526
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R 451.527
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R 451.528
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R 451.529
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R 451.530
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R 451.531
Source: 1997 AACS.

R 451.532
Source: 1997 AACS.

R 451.533
Source: 1997 AACS.
R 451.534
Source: 1997 AACS.

R 451.535
Source: 1997 AACS.

R 451.536

Source: 1997 AACS.

R 451.537
Source: 1997 AACS.

R 451.538
Source: 1997 AACS.

DIRECTOR'S OFFICE

SECURITIES

PART 1. PROHIBITED PRACTICES

R 451.601.0
Source: 1997 AACS.

PART 2. REGISTRATION OF BROKER-DEALERS, AGENTS, AND INVESTMENT ADVISORS

R 451.601.2
Source: 1991 AACS.

R 451.601.4
Source: 1982 AACS.

R 451.602.1
Source: 1980 AACS.

R 451.602.2
Source: 1983 AACS.

R 451.602.3
Source: 1980 AACS.

R 451.602.4
Source: 1991 AACS.

R 451.602.5
Source: 1997 AACS.

R 451.602.5a
Source: 1997 AACS.

R 451.602.6
Source: 1980 AACS.

R 451.602.9
Source: 1997 AACS.

R 451.602.10
Source: 1997 AACS.

R 451.602.11
Source: 1997 AACS.

R 451.602.12
Source: 1997 AACS.

R 451.602.13
Source: 1997 AACS.

R 451.602.14
Source: 1997 AACS.

R 451.603.4
Source: 1983 AACS.

R 451.603.5
Source: 1980 AACS.

R 451.604.1
Source: 1983 AACS.

R 451.604.2
Source: 1980 AACS.

R 451.604.3
Source: 1980 AACS.

R 451.604.4
Source: 1997 AACS.

R 451.605.1
Source: 1997 AACS.

R 451.605.2
Source: 1983 AACS.

PART 3. REGISTRATION OF SECURITIES

R 451.705.2
Source: 1997 AACS.

R 451.705.5
Source: 1997 AACS.

R 451.705.6
Source: 1980 AACS.

R 451.705.7
Source: 1983 AACS.

R 451.706.3
Source: 1997 AACS.

R 451.706.5
Source: 1997 AACS.

R 451.706.6
Source: 1997 AACS.

R 451.706.7
Source: 1997 AACS.

R 451.706.8
Source: 1983 AACS.

R 451.706.9
Source: 1997 AACS.

R 451.706.10
Source: 1997 AACS.

R 451.706.11
Source: 1997 AACS.

R 451.706.12
Source: 1997 AACS.

R 451.706.13
Source: 1997 AACS.

R 451.706.14
Source: 1997 AACS.

R 451.706.15
Source: 1997 AACS.

R 451.706.16
Source: 1997 AACS.

R 451.706.17
Source: 1997 AACS.

R 451.706.18
Source: 1997 AACS.

R 451.706.19
Source: 1997 AACS.

R 451.706.20
Source: 1997 AACS.

R 451.706.23
Source: 1997 AACS.

R 451.706.24
Source: 1997 AACS.

R 451.706.25
Source: 1981 AACS.

R 451.706.26
Source: 1983 AACS.

PART 4. GENERAL PROVISIONS

R 451.801.1
Source: 1980 AACS.

R 451.801.3
Source: 1980 AACS.

R 451.801.4
Source: 1981 AACS.

R 451.801.5
Source: 1997 AACS.

R 451.802.1
Source: 1997 AACS.

R 451.802.2
Source: 1980 AACS.

R 451.802.3
Source: 1997 AACS.

R 451.803.1
Source: 1997 AACS.

R 451.803.2
Source: 1980 AACS.

R 451.803.3
Source: 1980 AACS.

R 451.803.4
Source: 1980 AACS.

R 451.803.5
Source: 1980 AACS.

R 451.803.6
Source: 1997 AACS.

R 451.803.7
Source: 1991 AACS.

R 451.803.8
Source: 1993 AACS.

R 451.803.9
Source: 1993 AACS.

R 451.803.10
Source: 1993 AACS.

R 451.803.11
Source: 1993 AACS.

R 451.812.2
Source: 1980 AACS.

R 451.813.1
Source: 1997 AACS.

R 451.818.1
Source: 1982 AACS.

DEBT MANAGEMENT

R 451.1222
Source: 1985 AACS.

R 451.1224
Source: 1997 AACS.

CONDOMINIUMS

R 451.1301
Source: 1997 AACS.

R 451.1302
Source: 1997 AACS.

R 451.1304
Source: 1997 AACS.

R 451.1307
Source: 1997 AACS.

R 451.1309
Source: 1997 AACS.

R 451.1311
Source: 1997 AACS.

R 451.1315
Source: 1997 AACS.

R 451.1317
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R 451.1321
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R 451.1324
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R 451.1325
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R 451.1331
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R 451.1333
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R 451.1334
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R 451.1340
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R 451.1342
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R 451.1344
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R 451.1345
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R 451.1346
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R 451.1347
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R 451.1348
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R 451.1350
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R 451.1351
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R 451.1352
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R 451.1355
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R 451.1356
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R 451.1357
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R 451.1358
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R 451.1359
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R 451.1361
Source: 1997 AACS.

R 451.1363
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R 451.1371
Source: 1997 AACS.

R 451.1372
Source: 1997 AACS.

R 451.1373
Source: 1997 AACS.

R 451.1374
Source: 1997 AACS.

R 451.1377
Source: 1997 AACS.

R 451.1381
Source: 1997 AACS.

R 451.1382
Source: 1997 AACS.

R 451.1383
Source: 1997 AACS.

R 451.1384
Source: 1997 AACS.

R 451.1386
Source: 1997 AACS.

R 451.1387
Source: 1997 AACS.

PROCEDURAL RULES

PART 1. GENERAL PROVISIONS

R 451.2101
Source: 1983 AACS.

R 451.2102
Source: 1983 AACS.

R 451.2103
Source: 1983 AACS.

PART 2. BUREAU ORGANIZATION

R 451.2201
Source: 1983 AACS.

R 451.2202
Source: 1983 AACS.

R 451.2203
Source: 1983 AACS.

PART 3. INTERPRETATIVE OPINIONS AND DECLARATORY RULINGS

R 451.2301
Source: 1983 AACS.

R 451.2302
Source: 1983 AACS.

R 451.2303
Source: 2001 AACS.

R 451.2304
Source: 2001 AACS.

PART 4. OPPORTUNITY TO SHOW COMPLIANCE

R 451.2401
Source: 1983 AACS.

R 451.2402
Source: 1983 AACS.

R 451.2403
Source: 1983 AACS.

R 451.2404
Source: 1983 AACS.

R 451.2405
Source: 1983 AACS.

R 451.2406
Source: 1983 AACS.

R 451.2407
Source: 1983 AACS.

R 451.2408
Source: 1983 AACS.

PART 5. COMMENCEMENT OF PROCEEDINGS AND CONTESTED CASES

R 451.2501
Source: 1983 AACS.

R 451.2502
Source: 1983 AACS.

R 451.2503
Source: 1983 AACS.

R 451.2504
Source: 1983 AACS.

R 451.2505
Source: 1983 AACS.

R 451.2506
Source: 1983 AACS.

R 451.2507
Source: 1983 AACS.

R 451.2508
Source: 1983 AACS.

R 451.2509
Source: 1983 AACS.

R 451.2510
Source: 1983 AACS.

R 451.2511
Source: 1983 AACS.

PART 6. PLEADINGS, MOTION PRACTICE, AND INTERVENTION

R 451.2601
Source: 1983 AACS.

R 451.2602
Source: 1983 AACS.

R 451.2603
Source: 1983 AACS.

R 451.2604
Source: 1983 AACS.

R 451.2605
Source: 1983 AACS.

R 451.2606
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R 451.2607
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R 451.2608
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R 451.2609
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R 451.2610
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R 451.2611
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R 451.2612
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R 451.2613
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R 451.2614
Source: 1983 AACS.

R 451.2615
Source: 1983 AACS.

R 451.2616
Source: 1983 AACS.

R 451.2617
Source: 1983 AACS.

R 451.2618
Source: 1983 AACS.

PART 7. JOINT AND CONSOLIDATED PROCEEDINGS

R 451.2701
Source: 1983 AACS.

R 451.2702
Source: 1983 AACS.

PART 9. PREHEARING CONFERENCE

R 451.2901
Source: 1983 AACS.

R 451.2902
Source: 1983 AACS.

R 451.2903
Source: 1983 AACS.

R 451.2904
Source: 1983 AACS.

R 451.2905
Source: 1983 AACS.

PART 10. CONDUCT OF HEARINGS

R 451.3001
Source: 1983 AACS.

R 451.3002
Source: 1983 AACS.

R 451.3003
Source: 1983 AACS.

R 451.3004
Source: 1983 AACS.

R 451.3005
Source: 1983 AACS.

R 451.3006
Source: 1983 AACS.

R 451.3007
Source: 1983 AACS.

R 451.3008
Source: 1983 AACS.

R 451.3009
Source: 1983 AACS.

R 451.3010
Source: 1983 AACS.

R 451.3011
Source: 1983 AACS.

PART 12. DECISIONS

R 451.3201
Source: 1983 AACS.

R 451.3202
Source: 1983 AACS.

R 451.3203
Source: 1983 AACS.

R 451.3204
Source: 1983 AACS.

PART 13. PRESIDING OFFICER

R 451.3301

Source: 1983 AACS.

R 451.3302
Source: 1983 AACS.

R 451.3303
Source: 1983 AACS.

R 451.3304
Source: 1983 AACS.

R 451.3305
Source: 1983 AACS.

PART 14. MISCONDUCT BY ATTORNEYS, AUTHORIZED REPRESENTATIVES, AND PARTIES

R 451.3401
Source: 1983 AACS.

PART 15. PUBLIC HEARINGS

R 451.3501
Source: 1983 AACS.

R 451.3502
Source: 1983 AACS.

R 451.3503
Source: 1983 AACS.

DIRECTOR'S OFFICE

CEMETERIES

PART 2. PERMITS, REGISTRATIONS, LICENSES, AND RECORDS

R 456.122
Source: 1997 AACS.

R 456.135
Source: 1998-2000 AACS.

PART 4. CASKETS, EARTH BURIALS, ENTOMBMENTS, AND CREMATIONS

R 456.141
Source: 1998-2000 AACS.

R 456.142
Source: 1998-2000 AACS.

R 456.143
Source: 1998-2000 AACS.

PUBLIC SERVICE COMMISSION
PRACTICE AND PROCEDURE BEFORE THE COMMISSION

R 460.11
Source: 1997 AACS.

R 460.13
Source: 1997 AACS.

R 460.14
Source: 1997 AACS.

R 460.15
Source: 1997 AACS.

R 460.16
Source: 1997 AACS.

R 460.17
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R 460.18
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R 460.19
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R 460.21
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R 460.31
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R 460.51
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R 460.64
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R 460.71
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R 460.72
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R 460.74
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R 460.75
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R 460.76
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R 460.77
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R 460.78
Source: 1997 AACS.

R 460.79
Source: 1997 AACS.

R 460.80
Source: 1997 AACS.

R 460.99
Source: 1997 AACS.

UNIFORM SYSTEM OF ACCOUNTS FOR CLASS I MOTOR CARRIERS OF PASSENGERS AND PROPERTY

R 460.160—R 460.280
Source: 1997 AACS.

UNIFORM SYSTEM OF ACCOUNTS FOR CLASS II MOTOR CARRIERS OF PASSENGERS AND PROPERTY

R 460.290—R 460.407
Source: 1997 AACS.

UNIFORM SYSTEM OF ACCOUNTS FOR CLASS III MOTOR CARRIERS OF PASSENGERS AND PROPERTY

R 460.411—R 460.476
Source: 1997 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

PUBLIC SERVICE COMMISSION

ELECTRIC INTERCONNECTION STANDARDS

R 460.481
Source: 2003 AACS.

R 460.482
Source: 2003 AACS.

R 460.483
Source: 2003 AACS.

R 460.484
Source: 2003 AACS.

R 460.485
Source: 2003 AACS.

R 460.486
Source: 2003 AACS.

R 460.487
Source: 2003 AACS.

R 460.488
Source: 2003 AACS.

R 460.489
Source: 2003 AACS.

ELECTRICAL SERVICE

R 460.501
Source: 1997 AACS.

R 460.502
Source: 1997 AACS.

R 460.503
Source: 1997 AACS.

R 460.504
Source: 1997 AACS.

R 460.505
Source: 1997 AACS.

ELECTRICAL LINES AND EQUIPMENT

R 460.521
Source: 1997 AACS.

R 460.529
Source: 1997 AACS.

R 460.540
Source: 1997 AACS.

R 460.541
Source: 1997 AACS.

R 460.542
Source: 1997 AACS.

R 460.543
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R 460.544
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R 460.545
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R 460.546
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R 460.547
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R 460.548
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R 460.549
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R 460.570
Source: 1997 AACS.

R 460.571
Source: 1997 AACS.

R 460.572
Source: 1997 AACS.

PUBLIC SERVICE COMMISSION
ELECTRIC POWER AND COMMUNICATION LINES

R 460.581
Source: 1997 AACS.

R 460.582
Source: 1997 AACS.

R 460.583
Source: 1997 AACS.

R 460.584
Source: 1997 AACS.

R 460.585
Source: 1997 AACS.

R 460.586
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R 460.587
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R 460.588
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R 460.589
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R 460.590
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R 460.591

Source: 1997 AACS.

R 460.592
Source: 1997 AACS.

DEPARTMENT OF LABOR AND ECONOMIC GROWTH

PUBLIC SERVICE COMMISSION

SERVICE QUALITY AND RELIABILITY STANDARDS FOR ELECTRIC DISTRIBUTION SYSTEMS

PART 1. GENERAL PROVISIONS

R 460.701
Source: 2004 AACS.

R 460.702
Source: 2004 AACS.

R 460.703
Source: 2004 AACS.

PART 2. UNACCEPTABLE LEVELS OF PERFORMANCE

R 460.721
Source: 2004 AACS.

R 460.722
Source: 2004 AACS.

R 460.723
Source: 2004 AACS.

R 460.724
Source: 2004 AACS.

PART 3. RECORDS AND REPORTS

R 460.731
Source: 2004 AACS.

R 460.732
Source: 2004 AACS.

R 460.733
Source: 2004 AACS.

R 460.734
Source: 2004 AACS.

PART 4. FINANCIAL INCENTIVES AND PENALTIES

R 460.741
Source: 2004 AACS.

R 460.742
Source: 2004 AACS.

R 460.743
Source: 2004 AACS.

R 460.744
Source: 2004 AACS.

R 460.745
Source: 2004 AACS.

R 460.746
Source: 2004 AACS.

R 460.747
Source: 2004 AACS.

R 460.748
Source: 2004 AACS.

PART 5. WAIVERS AND EXCEPTIONS

R 460.751
Source: 2004 AACS.

R 460.752
Source: 2004 AACS.

ELECTRICAL SUPPLY AND COMMUNICATION LINES AND ASSOCIATED EQUIPMENT

R 460.811
Source: 1988 AACS.

R 460.812
Source: 1988 AACS.

R 460.813
Source: 1997 AACS.

R 460.814
Source: 1988 AACS.

R 460.815
Source: 1988 AACS.

STANDARDS OF GAS SERVICE

R 460.915
Source: 1997 AACS.

R 460.917
Source: 1997 AACS.

R 460.918

Source: 1997 AACS.

R 460.921
Source: 1997 AACS.

R 460.922
Source: 1997 AACS.

R 460.923
Source: 1997 AACS.

R 460.924
Source: 1997 AACS.

R 460.925
Source: 1997 AACS.

INTRASTATE TELEPHONE SERVICES AND FACILITIES (ORDER NO. T-576—1944 REVISION)

R 460.1960
Source: 1997 AACS.

FILING PROCEDURE FOR RATE SCHEDULES, FRANCHISES, PERMITS, CONTRACTS, AND AGREEMENTS BY ELECTRIC, TELEPHONE, AND GAS UTILITIES (ORDER NO. 3096—1944 REVISION)

R 460.2001
Source: 1997 AACS.

R 460.2002
Source: 1997 AACS.

R 460.2003
Source: 1997 AACS.

R 460.2004
Source: 1997 AACS.

R 460.2005
Source: 1997 AACS.

R 460.2006
Source: 1997 AACS.

R 460.2007
Source: 1997 AACS.

R 460.2008
Source: 1997 AACS.

FILING PROCEDURES FOR ELECTRIC, WATER, STEAM, AND GAS UTILITIES

PART 1. GENERAL PROVISIONS

R 460.2011
Source: 1981 AACS.

R 460.2012
Source: 1981 AACS.

R 460.2013
Source: 1981 AACS.

PART 2. RATE BOOK

R 460.2021
Source: 1981 AACS.

R 460.2022
Source: 1981 AACS.

R 460.2023
Source: 1981 AACS.

R 460.2024
Source: 1981 AACS.

PART 3. SPECIAL CONTRACTS

R 460.2031
Source: 1981 AACS.

FILING PROCEDURES FOR COMMUNICATIONS COMMON CARRIERS TARIFFS

R 460.2051
Source: 1981 AACS.

R 460.2052
Source: 1981 AACS.

R 460.2053
Source: 1981 AACS.

R 460.2054
Source: 1981 AACS.

R 460.2055
Source: 1981 AACS.

R 460.2056
Source: 1981 AACS.

R 460.2057
Source: 1981 AACS.

BILLING PRACTICES APPLICABLE TO COMMERCIAL AND INDUSTRIAL GAS CUSTOMERS

R 460.2071
Source: 1988 AACS.

R 460.2072
Source: 1988 AACS.

R 460.2073
Source: 1988 AACS.

R 460.2074
Source: 1988 AACS.

R 460.2075
Source: 1988 AACS.

R 460.2076
Source: 1988 AACS.

R 460.2077
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R 460.2078
Source: 1988 AACS.

R 460.2079
Source: 1988 AACS.

R 460.2080
Source: 1988 AACS.

R 460.2081
Source: 1988 AACS.

R 460.2082
Source: 1988 AACS.

R 460.2083
Source: 1989 AACS.

R 460.2084
Source: 1988 AACS.

R 460.2085
Source: 1988 AACS.

R 460.2086
Source: 1988 AACS.

CONSUMER STANDARDS AND BILLING PRACTICES ELECTRIC AND GAS RESIDENTIAL SERVICE

PART 1. GENERAL PROVISIONS

R 460.2101
Source: 1992 AACS.

R 460.2102
Source: 1998-2000 AACS.

R 460.2103
Source: 1992 AACS.

R 460.2105
Source: 1992 AACS.

PART 2. BILLING AND PAYMENT STANDARDS

R 460.2111
Source: 1998-2000 AACS.

R 460.2112
Source: 1998-2000 AACS.

R 460.2113
Source: 1992 AACS.

R 460.2114
Source: 1992 AACS.

R 460.2115
Source: 1992 AACS.

R 460.2116
Source: 1998-2000 AACS.

R 460.2117
Source: 1998-2000 AACS.

R 460.2118
Source: 1992 AACS.

R 460.2119
Source: 1998-2000 AACS.

R 460.2120
Source: 1998-2000 AACS.

R 460.2121
Source: 1998-2000 AACS.

R 460.2122
Source: 1992 AACS.

R 460.2123
Source: 1998-2000 AACS.

R 460.2124
Source: 1998-2000 AACS.

R 460.2125
Source: 1992 AACS.

PART 3. GUARANTEE OF PAYMENT; SECURITY DEPOSITS

R 460.2131
Source: 1998-2000 AACS.

R 460.2132
Source: 1998-2000 AACS.

R 460.2133
Source: 1998-2000 AACS.

R 460.2134
Source: 1998-2000 AACS.

R 460.2135
Source: 2001 AACS.

R 460.2136
Source: 1992 AACS.

R 460.2137
Source: 1997 AACS.

PART 4. UTILITY PROCEDURES

R 460.2141
Source: 1992 AACS.

R 460.2142
Source: 1992 AACS.

R 460.2143
Source: 1992 AACS.

R 460.2144
Source: 1992 AACS.

R 460.2145
Source: 1998-2000 AACS.

R 460.2146
Source: 1998-2000 AACS.

R 460.2147
Source: 1998-2000 AACS.

R 460.2148
Source: 1992 AACS.

R 460.2149
Source: 1992 AACS.

R 460.2150
Source: 1998-2000 AACS.

PART 5. PHYSICAL SHUTOFF OF SERVICE

R 460.2151
Source: 1998-2000 AACS.

R 460.2152
Source: 1992 AACS.

R 460.2153
Source: 1992 AACS.

R 460.2154
Source: 1992 AACS.

R 460.2155
Source: 1992 AACS.

PART 6. PROCEDURES FOR SHUTOFF OR TERMINATION OF SERVICE

R 460.2161
Source: 1992 AACS.

R 460.2162
Source: 1992 AACS.

R 460.2163
Source: 1998-2000 AACS.

R 460.2164
Source: 1992 AACS.

R 460.2165
Source: 1998-2000 AACS.

R 460.2166
Source: 1992 AACS.

R 460.2167
Source: 1992 AACS.

R 460.2168
Source: 1998-2000 AACS.

R 460.2169
Source: 1998-2000 AACS.

R 460.2170
Source: 1998-2000 AACS.

R 460.2171
Source: 1992 AACS.

R 460.2172
Source: 1992 AACS.

R 460.2173
Source: 1992 AACS.

R 460.2174
Source: 1992 AACS.

PART 7. COMMISSION APPEAL PROCEDURES

R 460.2181
Source: 1992 AACS.

R 460.2182
Source: 1992 AACS.

R 460.2183
Source: 1992 AACS.

R 460.2184
Source: 1992 AACS.

R 460.2185
Source: 1992 AACS.

R 460.2186
Source: 1992 AACS.

R 460.2187
Source: 1992 AACS.

R 460.2188
Source: 1992 AACS.

R 460.2189
Source: 1992 AACS.

R 460.2190
Source: 1992 AACS.

R 460.2191
Source: 1992 AACS.

R 460.2192
Source: 1992 AACS.

CONSUMER STANDARDS AND BILLING PRACTICES—RESIDENTIAL TELEPHONE SERVICE

PART 1. GENERAL PROVISIONS AND DEFINITIONS

R 460.2211
Source: 1997 AACS.

R 460.2212
Source: 1997 AACS.

R 460.2213
Source: 1997 AACS.

R 460.2214
Source: 1997 AACS.

R 460.2215
Source: 1997 AACS.

R 460.2216
Source: 1997 AACS.

PART 2. BILLING AND PAYMENT STANDARDS

R 460.2221
Source: 1997 AACS.

R 460.2222
Source: 1997 AACS.

R 460.2223
Source: 1997 AACS.

R 460.2224
Source: 1997 AACS.

R 460.2225
Source: 1997 AACS.

R 460.2226
Source: 1997 AACS.

R 460.2227
Source: 1997 AACS.

R 460.2228
Source: 1997 AACS.

R 460.2229
Source: 1997 AACS.

PART 3. GUARANTEE OF PAYMENT; SECURITY DEPOSITS

R 460.2231
Source: 1997 AACS.

R 460.2232
Source: 1997 AACS.

R 460.2233
Source: 1997 AACS.

R 460.2234
Source: 1997 AACS.

R 460.2235
Source: 1997 AACS.

R 460.2236
Source: 1997 AACS.

R 460.2237
Source: 1997 AACS.

PART 4. TELEPHONE UTILITY PROCEDURES

R 460.2241
Source: 1997 AACS.

R 460.2242
Source: 1997 AACS.

R 460.2243
Source: 1997 AACS.

R 460.2244
Source: 1997 AACS.

R 460.2245
Source: 1997 AACS.

R 460.2246
Source: 1997 AACS.

R 460.2247
Source: 1997 AACS.

R 460.2248
Source: 1997 AACS.

R 460.2249
Source: 1997 AACS.

PART 5. DISCONTINUATION OF SERVICE

R 460.2251
Source: 1997 AACS.

R 460.2252
Source: 1997 AACS.

R 460.2253
Source: 1997 AACS.

R 460.2254
Source: 1997 AACS.

R 460.2255
Source: 1997 AACS.

R 460.2256
Source: 1997 AACS.

R 460.2257
Source: 1997 AACS.

R 460.2258
Source: 1997 AACS.

R 460.2259
Source: 1997 AACS.

PART 6. HEARINGS; SETTLEMENT AGREEMENTS

R 460.2261
Source: 1997 AACS.

R 460.2262
Source: 1997 AACS.

R 460.2263
Source: 1997 AACS.

R 460.2264
Source: 1997 AACS.

R 460.2265
Source: 1997 AACS.

R 460.2266
Source: 1997 AACS.

R 460.2267
Source: 1997 AACS.

R 460.2268
Source: 1997 AACS.

PART 7. COMMISSION APPEAL PROCEDURE

R 460.2271
Source: 1997 AACS.

R 460.2272
Source: 1997 AACS.

R 460.2273
Source: 1997 AACS.

R 460.2274
Source: 1997 AACS.

R 460.2275
Source: 1997 AACS.

R 460.2276
Source: 1997 AACS.

R 460.2277
Source: 1997 AACS.

R 460.2278
Source: 1997 AACS.

R 460.2279
Source: 1997 AACS.

TECHNICAL STANDARDS FOR GAS SERVICE

PART 1. GENERAL PROVISIONS

R 460.2301
Source: 1993 AACS.

R 460.2302
Source: 1993 AACS.

PART 2. RECORDS, REPORTS, AND OTHER INFORMATION

R 460.2321
Source: 1993 AACS.

R 460.2323

Source: 1993 AACS.

PART 3. SERVICE REQUIREMENTS

R 460.2331
Source: 1993 AACS.

R 460.2332
Source: 1993 AACS.

R 460.2333
Source: 1993 AACS.

R 460.2335
Source: 1993 AACS.

PART 4. ENGINEERING

R 460.2342
Source: 1993 AACS.

R 460.2343
Source: 1993 AACS.

PART 5. INSPECTION OF METERS

R 460.2351
Source: 1993 AACS.

R 460.2352
Source: 1993 AACS.

R 460.2354
Source: 1993 AACS.

R 460.2355
Source: 1993 AACS.

R 460.2356
Source: 1993 AACS.

R 460.2357
Source: 1993 AACS.

PART 6. BILL ADJUSTMENT; METER ACCURACY

R 460.2361
Source: 1993 AACS.

R 460.2362
Source: 1993 AACS.

R 460.2363
Source: 1993 AACS.

R 460.2364
Source: 1993 AACS.

PART 7. SHUTOFF OF SERVICE

R 460.2371
Source: 1993 AACS.

R 460.2372
Source: 1993 AACS.

R 460.2373
Source: 1993 AACS.

R 460.2374
Source: 1993 AACS.

PART 8. GAS QUALITY

R 460.2381
Source: 1993 AACS.

R 460.2382
Source: 1993 AACS.

R 460.2383
Source: 1993 AACS.

R 460.2384
Source: 1993 AACS.

PRESERVATION OF RECORDS OF ELECTRIC, GAS, AND WATER UTILITIES

R 460.2501
Source: 1998-2000 AACS.

R 460.2502
Source: 1998-2000 AACS.

R 460.2503
Source: 1998-2000 AACS.

R 460.2504
Source: 1998-2000 AACS.

R 460.2505
Source: 1998-2000 AACS.

R 460.2506
Source: 1998-2000 AACS.

R 460.2507
Source: 1998-2000 AACS.

R 460.2508
Source: 1998-2000 AACS.

R 460.2509
Source: 1998-2000 AACS.

R 460.2510
Source: 1998-2000 AACS.

R 460.2511
Source: 1998-2000 AACS.

R 460.2512
Source: 1998-2000 AACS.

R 460.2513
Source: 1998-2000 AACS.

R 460.2514
Source: 1998-2000 AACS.

R 460.2515
Source: 1998-2000 AACS.

R 460.2516
Source: 1998-2000 AACS.

R 460.2517
Source: 1998-2000 AACS.

R 460.2518
Source: 1998-2000 AACS.

R 460.2519
Source: 1998-2000 AACS.

R 460.2520
Source: 1998-2000 AACS.

R 460.2521
Source: 1998-2000 AACS.

R 460.2522
Source: 1998-2000 AACS.

R 460.2523
Source: 1998-2000 AACS.

R 460.2524
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R 460.2525
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R 460.2526
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R 460.2527
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R 460.2528

Source: 1998-2000 AACS.

R 460.2529
Source: 1998-2000 AACS.

R 460.2530
Source: 1998-2000 AACS.

R 460.2531
Source: 1998-2000 AACS.

R 460.2532
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R 460.2533
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R 460.2534
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R 460.2535
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R 460.2536
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R 460.2537
Source: 1998-2000 AACS.

R 460.2538
Source: 1998-2000 AACS.

R 460.2539
Source: 1998-2000 AACS.

R 460.2540
Source: 1998-2000 AACS.

R 460.2541
Source: 1998-2000 AACS.

R 460.2542
Source: 1998-2000 AACS.

R 460.2543
Source: 1998-2000 AACS.

R 460.2544
Source: 1998-2000 AACS.

R 460.2545
Source: 1998-2000 AACS.

R 460.2546
Source: 1998-2000 AACS.

R 460.2547
Source: 1998-2000 AACS.

R 460.2548
Source: 1998-2000 AACS.

R 460.2549
Source: 1998-2000 AACS.

R 460.2550
Source: 1998-2000 AACS.

R 460.2551
Source: 1998-2000 AACS.

R 460.2552
Source: 1998-2000 AACS.

R 460.2553
Source: 1998-2000 AACS.

R 460.2554
Source: 1998-2000 AACS.

R 460.2555
Source: 1998-2000 AACS.

R 460.2556
Source: 1998-2000 AACS.

R 460.2557
Source: 1998-2000 AACS.

R 460.2558
Source: 1998-2000 AACS.

R 460.2559
Source: 1998-2000 AACS.

R 460.2560
Source: 1998-2000 AACS.

R 460.2561
Source: 1998-2000 AACS.

R 460.2562
Source: 1998-2000 AACS.

R 460.2563
Source: 1998-2000 AACS.

R 460.2564
Source: 1998-2000 AACS.

R 460.2565
Source: 1998-2000 AACS.

R 460.2566
Source: 1998-2000 AACS.

R 460.2567
Source: 1998-2000 AACS.

R 460.2568
Source: 1998-2000 AACS.

R 460.2569
Source: 1998-2000 AACS.

R 460.2570
Source: 1998-2000 AACS.

R 460.2571
Source: 1998-2000 AACS.

R 460.2572
Source: 1998-2000 AACS.

R 460.2573
Source: 1998-2000 AACS.

R 460.2574
Source: 1998-2000 AACS.

R 460.2575
Source: 1998-2000 AACS.

R 460.2576
Source: 1998-2000 AACS.

R 460.2577
Source: 1998-2000 AACS.

R 460.2578
Source: 1998-2000 AACS.

R 460.2579
Source: 1998-2000 AACS.

R 460.2580
Source: 1998-2000 AACS.

R 460.2581
Source: 1998-2000 AACS.

R 460.2582
Source: 1998-2000 AACS.

PUBLIC SERVICE COMMISSION

UNCOLLECTIBLES ALLOWANCE RECOVERY FUNDS

PART 1. GENERAL PROVISIONS

R 460.2601
Source: 2001 AACS.

R 460.2602
Source: 2001 AACS.

PART 2. UNCOLLECTIBLES ALLOWANCE RECOVERY FUND

R 460.2621
Source: 2001 AACS.

R 460.2622
Source: 2001 AACS.

R 460.2623
Source: 2001 AACS.

R 460.2624
Source: 2001 AACS.

R 460.2625
Source: 2001 AACS.

SERVICES SUPPLIED BY ELECTRIC UTILITIES

PART 1. GENERAL PROVISIONS

R 460.3101
Source: 1996 AACS.

R 460.3102
Source: 1996 AACS.

R 460.3103
Source: 1983 AACS.

PART 2. RECORDS AND REPORTS

R 460.3201
Source: 1996 AACS.

R 460.3202
Source: 1983 AACS.

R 460.3203
Source: 1996 AACS.

PART 3. METER REQUIREMENTS

R 460.3301
Source: 1996 AACS.

R 460.3302
Source: 1997 AACS.

R 460.3303
Source: 1996 AACS.

R 460.3304
Source: 1996 AACS.

R 460.3305
Source: 1996 AACS.

R 460.3306
Source: 1996 AACS.

R 460.3307
Source: 1997 AACS.

R 460.3308
Source: 1996 AACS.

PART 4. CUSTOMER RELATIONS

R 460.3401
Source: 1996 AACS.

R 460.3402
Source: 1996 AACS.

R 460.3403
Source: 1996 AACS.

R 460.3404
Source: 1996 AACS.

R 460.3405
Source: 1997 AACS.

R 460.3406
Source: 1996 AACS.

R 460.3407
Source: 1996 AACS.

R 460.3408
Source: 1996 AACS.

R 460.3409
Source: 1996 AACS.

R 460.3410
Source: 1996 AACS.

R 460.3411
Source: 1996 AACS.

PART 5. CONSTRUCTION, OPERATIONS, AND MAINTENANCE

R 460.3501
Source: 1983 AACS.

R 460.3502
Source: 1996 AACS.

R 460.3503
Source: 1996 AACS.

R 460.3504
Source: 1996 AACS.

R 460.3505
Source: 1996 AACS.

PART 6. METERING EQUIPMENT INSPECTIONS AND TESTS

R 460.3601
Source: 1983 AACS.

R 460.3602
Source: 1983 AACS.

R 460.3603
Source: 1983 AACS.

R 460.3604
Source: 1995 AACS.

R 460.3605
Source: 1983 AACS.

R 460.3606
Source: 1983 AACS.

R 460.3607
Source: 1983 AACS.

R 460.3608
Source: 1983 AACS.

R 460.3609
Source: 1983 AACS.

R 460.3610
Source: 1983 AACS.

R 460.3611
Source: 1995 AACS.

R 460.3612
Source: 1995 AACS.

R 460.3613
Source: 1995 AACS.

R 460.3614
Source: 1983 AACS.

R 460.3615
Source: 1983 AACS.

R 460.3616
Source: 1983 AACS.

R 460.3617
Source: 1995 AACS.

R 460.3618

Source: 1983 AACS.

PART 7. STANDARDS OF QUALITY OF SERVICES

R 460.3701
Source: 1996 AACS.

R 460.3702
Source: 1996 AACS.

R 460.3703
Source: 1996 AACS.

R 460.3704
Source: 1996 AACS.

R 460.3705
Source: 1996 AACS.

PART 8. SAFETY

R 460.3801
Source: 1983 AACS.

R 460.3802
Source: 1996 AACS.

R 460.3803
Source: 1996 AACS.

R 460.3804
Source: 1996 AACS.

PART 9. COMMERCIAL AND INDUSTRIAL STANDARDS AND BILLING PRACTICES

R 460.3901
Source: 1996 AACS.

R 460.3902
Source: 1996 AACS.

R 460.3903
Source: 1996 AACS.

R 460.3904
Source: 1996 AACS.

R 460.3905
Source: 1996 AACS.

R 460.3906
Source: 1996 AACS.

R 460.3907
Source: 1996 AACS.

R 460.3908
Source: 1996 AACS.

UNIFORM SYSTEM OF ACCOUNTS FOR MAJOR AND NONMAJOR ELECTRIC UTILITIES

R 460.9001
Source: 1997 AACS.

R 460.9019
Source: 1997 AACS.

UNIFORM SYSTEM OF ACCOUNTS FOR MAJOR AND NONMAJOR GAS UTILITIES

R 460.9021
Source: 1988 AACS.

R 460.9039
Source: 1988 AACS.

UNIFORM SYSTEM OF ACCOUNTS FOR CLASS A AND CLASS B TELEPHONE COMPANIES

R 460.9041
Source: 1988 AACS.

R 460.9059
Source: 1988 AACS.

R 460.9060
Source: 1997 AACS.

R 460.9079
Source: 1997 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

PUBLIC SERVICE COMMISSION

UNIFORM SYSTEM OF ACCOUNTS FOR CLASS A AND B WATER UTILITIES

R 460.9081
Source: 1998-2000 AACS.

R 460.9099
Source: 1998-2000 AACS.

SERVICES SUPPLIED BY WATER UTILITIES

R 460.13101 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13102 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13103 Rescinded.

History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13104 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13105 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13106 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13107 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

200. RECORDS AND REPORTS

R 460.13201 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13202 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13203 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13204 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13205 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13206 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13207 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

300. GENERAL REQUIREMENTS

R 460.13301 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13302 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13303 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13304 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13305 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13306 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

400. CUSTOMER RELATIONS

R 460.13401 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13402 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13403 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13404 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13405 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13406 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13407 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13408 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13409 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13410 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

500. ENGINEERING

R 460.13501 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13502 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

600. METER INSPECITONS AND TESTS

R 460.13601 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13602 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13603 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13604 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13605 Rescinded.

History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13606 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

700. STANDARDS OF QUALITY OF SERVICES

R 460.13701 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13702 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13703 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13704 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13705 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13706 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

R 460.13707 Rescinded.
History: 1954 ACS 36, Eff. Nov. 14, 1963; 2005 MR 11, Eff. June 14, 2005

MICHIGAN GAS SAFETY CODE

PART 1. GENERAL PROVISIONS

R 460.14001
Source: 1998-2000 AACS.

R 460.14003
Source: 1998-2000 AACS.

R 460.14004
Source: 1998-2000 AACS.

R 460.14005
Source: 1998-2000 AACS.

R 460.14006
Source: 1998-2000 AACS.

R 460.14008
Source: 1998-2000 AACS.

R 460.l4009
Source: 1998-2000 AACS.

R 460.14011
Source: 1998-2000 AACS.

R 460.14012
Source: 1998-2000 AACS.

R 460.14013
Source: 1998-2000 AACS.

R 460.14015
Source: 1998-2000 AACS.

R 460.14017
Source: 1998-2000 AACS.

R 460.14018
Source: 1998-2000 AACS.

PART 2. ANNUAL REPORTS, INCIDENT REPORTS, AND SAFETY-RELATED CONDITION REPORTS

R 460.14021
Source: 1998-2000 AACS.

R 460.14025
Source: 1998-2000 AACS.

R 460.14026
Source: 1998-2000 AACS.

R 460.14027
Source: 1998-2000 AACS.

R 460.14029
Source: 1998-2000 AACS.

R 460.14031
Source: 1998-2000 AACS.

R 460.14033
Source: 1998-2000 AACS.

R 460.14035
Source: 1998-2000 AACS.

R 460.14037
Source: 1998-2000 AACS.

R 460.14038
Source: 1998-2000 AACS.

R 460.14039
Source: 1998-2000 AACS.

R 460.14040
Source: 1998-2000 AACS.

PART 3. SAFETY STANDARDS

R 460.14041
Source: 1998-2000 AACS.

R 460.14045
Source: 1998-2000 AACS.

R 460.14047
Source: 1998-2000 AACS.

R 460.14049
Source: 1998-2000 AACS.

R 460.14051
Source: 1998-2000 AACS.

R 460.14053
Source: 1998-2000 AACS.

R 460.14054
Source: 1998-2000 AACS.

R 460.14057
Source: 1998-2000 AACS.

R 460.14059
Source: 1998-2000 AACS.

PART 4. MATERIALS

R 460.14061
Source: 1998-2000 AACS.

R 460.14063
Source: 1998-2000 AACS.

R 460.14064
Source: 1998-2000 AACS.

R 460.14065
Source: 1998-2000 AACS.

R 460.14069
Source: 1998-2000 AACS.

R 460.14073
Source: 1998-2000 AACS.

R 460.14075
Source: 1998-2000 AACS.

PART 5. PIPE DESIGN

R 460.14101
Source: 1998-2000 AACS.

R 460.14103
Source: 1998-2000 AACS.

R 460.14105
Source: 1998-2000 AACS.

R 460.14107
Source: 1998-2000 AACS.

R 460.14109
Source: 1998-2000 AACS.

R 460.14111
Source: 1998-2000 AACS.

R 460.14113
Source: 1998-2000 AACS.

R 460.14115
Source: 1998-2000 AACS.

R 460.14117
Source: 1998-2000 AACS.

R 460.14119
Source: 1998-2000 AACS.

R 460.14121
Source: 1998-2000 AACS.

R 460.14123
Source: 1998-2000 AACS.

R 460.14125
Source: 1998-2000 AACS.

PART 6. PIPELINE COMPONENTS DESIGN

R 460.14141
Source: 1998-2000 AACS.

R 460.14143
Source: 1998-2000 AACS.

R 460.14144
Source: 1998-2000 AACS.

R 460.14145
Source: 1998-2000 AACS.

R 460.14147
Source: 1998-2000 AACS.

R 460.14149
Source: 1998-2000 AACS.

R 460.14150
Source: 1998-2000 AACS.

R 460.14151
Source: 1998-2000 AACS.

R 460.14153

Source: 1998-2000 AACS.

R 460.14155
Source: 1998-2000 AACS.

R 460.14157
Source: 1998-2000 AACS.

R 460.14159
Source: 1998-2000 AACS.

R 460.14161
Source: 1998-2000 AACS.

R 460.14163
Source: 1998-2000 AACS.

R 460.14165
Source: 1998-2000 AACS.

R 460.14167
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R 460.14169
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R 460.14171
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R 460.14173
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R 460.14174
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R 460.14175
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R 460.14177
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R 460.14179
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R 460.14181
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R 460.14183
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R 460.14185
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R 460.14187
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R 460.14189
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R 460.14191
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R 460.14193
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R 460.14195
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R 460.14197
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R 460.14199
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R 460.14201
Source: 1998-2000 AACS.

R 460.14203
Source: 1998-2000 AACS.

PART 7. WELDING STEEL IN PIPELINES

R 460.14221
Source: 1998-2000 AACS.

R 460.14223
Source: 1998-2000 AACS.

R 460.14225
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R 460.14227
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R 460.14229
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R 460.14230
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R 460.14231
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R 460.14235
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R 460.14239
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R 460.14241
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R 460.14243
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R 460.14245
Source: 1998-2000 AACS.

PART 8. JOINING OF MATERIALS OTHER THAN BY WELDING

R 460.14271
Source: 1998-2000 AACS.

R 460.14273
Source: 1998-2000 AACS.

R 460.14275
Source: 1998-2000 AACS.

R 460.14277
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R 460.14279
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R 460.14281
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R 460.14283
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R 461.14285
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R 460.14287
Source: 1998-2000 AACS.

PART 9. GENERAL CONSTRUCTION REQUIREMENTS FOR TRANSMISSION LINES AND MAINS

R 460.14301
Source: 1998-2000 AACS.

R 460.14303
Source: 1998-2000 AACS.

R 460.14305
Source: 1998-2000 AACS.

R 460.14307
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R 460.14309
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R 460.14311
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R 460.14321
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R 460.14323
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R 460.14325
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R 460.14327
Source: 1998-2000 AACS.

PART 10. CUSTOMER METERS; SERVICE REGULATORS; SERVICE LINES

R 460.14351
Source: 1998-2000 AACS.

R 460.14353
Source: 1998-2000 AACS.

R 460.14355
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R 460.14357
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R 460.14379
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PART 11. CORROSION CONTROL

R 460.14451
Source: 1998-2000 AACS.

R 460.14452
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R 460.14453
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R 460.14454
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R 460.14457
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R 460.14459
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R 460.14461
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R 460.14463
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R 460.14465
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R 460.14469
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R 460.14471
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R 460.14473
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R 460.14475
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R 460.14479
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R 460.14483
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R 460.14485
Source: 1998-2000 AACS.

R 460.14487
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R 460.14489
Source: 1998-2000 AACS.

PART 12. TEST REQUIREMENTS

R 460.14501
Source: 1998-2000 AACS.

R 460.14503
Source: 1998-2000 AACS.

R 460.14505
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R 460.14507
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R 460.14509
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R 460.14511
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R 460.14513
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R 460.14515
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R 460.14517
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PART 13. UPDATING

R 460.14551
Source: 1998-2000 AACS.

R 460.14553
Source: 1998-2000 AACS.

R 460.14555
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R 460.14557
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PART 14. OPERATIONS

R 460.14601
Source: 1998-2000 AACS.

R 460.14603
Source: 1998-2000 AACS.

R 460.14605
Source: 1998-2000 AACS.

R 460.14606
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R 460.14609
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PART 15. MAINTENANCE

R 460.14701
Source: 1998-2000 AACS.

R 460.14703
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R 460.14705
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R 460.14706
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R 460.14709
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R 460.14743
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R 460.14747
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R 460.14749
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R 460.14751
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R 460.14753
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R 460.14755
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PART 16. RECORDS AND REPORTS

R 460.14801
Source: 1998-2000 AACS.

R 460.14803
Source: 1998-2000 AACS.

R 460.14805
Source: 1998-2000 AACS.

PART 19. APPENDIXES AND RESCISSION

R 460.14901
Source: 1998-2000 AACS.

R 460.14902
Source: 1998-2000 AACS.

R 460.14903
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R 460.14904
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R 460.14905
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R 460.14906
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R 460.14959
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R 460.14961
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R 460.14966
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R 460.14967
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R 460.14999
Source: 1998-2000 AACS.

MOTOR CARRIERS

R 460.15001
Source: 1997 AACS.

R 460.15019
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R 460.15021
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R 460.15022
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R 460.15098
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R 460.15101
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R 460.15103
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R 460.15104
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R 460.15105
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R 460.15106
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R 460.15107
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R 460.15112
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R 460.15114
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R 460.15119
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R 460.15121
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R 460.15122
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R 460.15124
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R 460.15126
Source: 1997 AACS.

R 460.15131

Source: 1997 AACS.

R 460.15133
Source: 1997 AACS.

DEPARTMENT OF STATE POLICE

MOTOR CARRIER DIVISION

MOTOR CARRIER SAFETY

PART 1. GENERAL PROVISIONS

R 460.16101
Source: 1997 AACS.

R 460.16105
Source: 1997 AACS.

R 460.16110
Source: 1997 AACS.

R 460.16112
Source: 1997 AACS.

R 460.16114
Source: 1997 AACS.

R 460.16115
Source: 1997 AACS.

R 460.16120
Source: 1997 AACS.

PART 2. QUALIFICATIONS OF DRIVERS

R 460.16201
Source: 1997 AACS.

R 460.16202
Source: 1997 AACS.

R 460.16203
Source: 1997 AACS.

R 460.16204
Source: 1997 AACS.

QUALIFICATION AND DISQUALIFICATION OF DRIVERS

R 460.16205
Source: 1997 AACS.

R 460.16205a
Source: 1997 AACS.

R 460.16206
Source: 1997 AACS.

R 460.16207
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R 460.16210
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R 460.16211
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R 460.16216
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R 460.16217
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R 460.16218
Source: 1997 AACS.

R 460.16218a
Source: 1997 AACS.

R 460.16218b
Source: 1997 AACS.

FILES AND RECORDS

R 460.16219
Source: 1997 AACS.

R 460.16220
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R 460.16221
Source: 1997 AACS.

R 460.16222
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R 460.16223
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PART 3. DRIVING OF MOTOR VEHICLES

R 460.16301
Source: 1997 AACS.

R 460.16302
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R 460.16303
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R 460.16304
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R 460.16321
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R 460.16322
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R 460.16323
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R 460.16324
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USE OF LIGHTED LAMPS AND REFLECTORS

R 460.16325
Source: 1997 AACS.

R 460.16326
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R 460.16335a
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R 460.16336
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R 460.16337
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R 460.16338
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PART 4. PARTS AND ACCESSORIES FOR SAFE OPERATION

R 460.16401
Source: 1997 AACS.

R 460.16402
Source: 1997 AACS.

R 460.16403
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R 460.16404
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R 460.16435
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R 460.16436
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GLAZING AND WINDOW CONSTRUCTION

R 460.16437
Source: 1997 AACS.

R 460.16438
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R 460.16439
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R 460.16440
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R 460.16441
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R 460.16442
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R 460.16443
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MISCELLANEOUS PARTS AND ACCESSORIES

R 460.16444
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R 460.16445
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R 460.16446
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R 460.16457
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R 460.16458
Source: 1997 AACS.

EMERGENCY EQUIPMENT

R 460.16459
Source: 1997 AACS.

PROTECTION AGAINST SHIFTING OR FALLING CARGO

R 460.16460
Source: 1997 AACS.

R 460.16461
Source: 1997 AACS.

R 460.16462
Source: 1997 AACS.

R 460.16463
Source: 1997 AACS.

PART 5. NOTIFICATION, REPORTING, AND RECORDING OF ACCIDENTS

R 460.16501
Source: 1997 AACS.

R 460.16510
Source: 1997 AACS.

R 460.16515
Source: 1997 AACS.

R 460.16520
Source: 1997 AACS.

R 460.16525
Source: 1997 AACS.

R 460.16530
Source: 1997 AACS.

PART 6. HOURS OF SERVICE OF DRIVERS

R 460.16601
Source: 1997 AACS.

R 460.16605
Source: 1997 AACS.

R 460.16610
Source: 1997 AACS.

R 460.16615
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R 460.16635
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R 460.16640
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R 460.16645
Source: 1997 AACS.

PART 7. INSPECTION AND MAINTENANCE

R 460.16701
Source: 1997 AACS.

R 460.16705
Source: 1997 AACS.

R 460.16710
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R 460.16715
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R 460.16725
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R 460.16730
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R 460.16735
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R 460.16740
Source: 1997 AACS.

PART 8. TRANSPORTATION OF HAZARDOUS MATERIALS; DRIVING AND PARKING RULES

R 460.16801
Source: 1997 AACS.

R 460.16810
Source: 1997 AACS.

R 460.16815
Source: 1997 AACS.

R 460.16820
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R 460.16840
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R 460.16845
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R 460.16850
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R 460.16855
Source: 1997 AACS.

R 460.16860
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R 460.16865
Source: 1997 AACS.

R 460.16870
Source: 1997 AACS.

PART 9. APPENDIX A

R 460.16901
Source: 1997 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

PUBLIC SERVICE COMMISSION

PRACTICE AND PROCEDURE BEFORE THE COMMISSION

PART 1. GENERAL PROVISIONS

R 460.17101
Source: 1992 AACS.

R 460.17103
Source: 1992 AACS.

R 460.17105
Source: 1992 AACS.

R 460.17107
Source: 1992 AACS.

R 460.17109
Source: 1992 AACS.

R 460.17111
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R 460.17113
Source: 1992 AACS.

R 460.17115
Source: 1992 AACS.

R 460.17117
Source: 1992 AACS.

PART 2. INTERVENTIONS

R 460.17201
Source: 1992 AACS.

R 460.17203
Source: 1992 AACS.

R 460.17205
Source: 1992 AACS.

R 460.17207
Source: 1992 AACS.

R 460.17209
Source: 1992 AACS.

PART 3. HEARINGS

R 460.17301
Source: 1992 AACS.

R 460.17303
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R 460.17305
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R 460.17307
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R 460.17309
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R 460.17337
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R 460.17339
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R 460.17341
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PART 4. REOPENINGS AND REHEARINGS

R 460.17401
Source: 1992 AACS.

R 460.17403
Source: 1992 AACS.

R 460.17405
Source: 1992 AACS.

PART 5. COMPLAINTS

R 460.17501
Source: 1997 AACS.

R 460.17503
Source: 1992 AACS.

R 460.17505
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R 460.17507
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R 460.17509
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R 460.17511
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R 460.17513
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R 460.17515
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PART 6. SPECIFIC PROCEEDINGS

R 460.17601
Source: 1997 AACS.

R 460.17603
Source: 1997 AACS.

R 460.17605
Source: 1997 AACS.

R 460.17607
Source: 1997 AACS.

PART 7. DECLARATORY RULINGS

R 460.17701
Source: 1992 AACS.

MOTOR CARRIERS

PART 1. GENERAL PROVISIONS

R 460.18101
Source: 1988 AACS.

R 460.18105
Source: 1984 AACS.

R 460.18106
Source: 1988 AACS.

R 460.18199
Source: 1984 AACS.

PART 2. APPLICATION FOR MOTOR CARRIER CERTIFICATE OR PERMIT

R 460.18201
Source: 1988 AACS.

R 460.18202
Source: 1988 AACS.

R 460.18203
Source: 1988 AACS.

R 460.18204
Source: 1984 AACS.

R 460.18205
Source: 1984 AACS.

R 460.18206
Source: 1984 AACS.

R 460.18207
Source: 1997 AACS.

R 460.18208
Source: 1984 AACS.

R 460.18209
Source: 1984 AACS.

R 460.18212
Source: 1984 AACS.

PART 3. MODIFIED PROCEDURE

R 460.18301
Source: 1984 AACS.

R 460.18302
Source: 1984 AACS.

R 460.18303
Source: 1988 AACS.

R 460.18304
Source: 1984 AACS.

R 460.18307
Source: 1984 AACS.

R 460.18308
Source: 1984 AACS.

PART 4. CERTIFICATES AND PERMITS

R 460.18401
Source: 1984 AACS.

R 460.18402

Source: 1984 AACS.

R 460.18403
Source: 1988 AACS.

R 460.18404
Source: 1984 AACS.

R 460.18405
Source: 1984 AACS.

R 460.18406
Source: 1984 AACS.

R 460.18407
Source: 1984 AACS.

R 460.18408
Source: 1988 AACS.

R 460.18409
Source: 1988 AACS.

R 460.18410
Source: 1984 AACS.

R 460.18411
Source: 1984 AACS.

R 460.18412
Source: 1984 AACS.

R 460.18413
Source: 1988 AACS.

PART 5. IDENTIFICATION OF VEHICLE

R 460.18501
Source: 1984 AACS.

R 460.18502
Source: 1984 AACS.

R 460.18503
Source: 1988 AACS.

R 460.18504
Source: 1984 AACS.

R 460.18505
Source: 1988 AACS.

PART 6. TRANSFER OF AUTHORITY

R 460.18601
Source: 1984 AACS.

R 460.18602
Source: 1984 AACS.

R 460.18603
Source: 1984 AACS.

R 460.18604
Source: 1984 AACS.

R 460.18605
Source: 1984 AACS.

R 460.18606
Source: 1984 AACS.

R 460.18607
Source: 1984 AACS.

R 460.18609
Source: 1984 AACS.

R 460.18610
Source: 1988 AACS.

R 460.18611
Source: 1988 AACS.

PART 7. SHIPPING DOCUMENTS AND PAYMENT OF FREIGHT CHARGES

R 460.18701
Source: 1988 AACS.

R 460.18703
Source: 1988 AACS.

R 460.18705
Source: 1988 AACS.

R 460.18706
Source: 1988 AACS.

R 460.18707
Source: 1984 AACS.

R 460.18708
Source: 1988 AACS.

R 460.18710
Source: 1984 AACS.

R 460.18711
Source: 1984 AACS.

PART 8. ACCOUNTING AND REPORTING PROCEDURES

R 460.18801
Source: 1988 AACS.

R 460.18802
Source: 1988 AACS.

PART 9. EMERGENCY-TEMPORARY AND TEMPORARY AUTHORITY

R 460.18901
Source: 1984 AACS.

R 460.18902
Source: 1984 AACS.

R 460.18903
Source: 1984 AACS.

R 460.18904
Source: 1984 AACS.

R 460.18906
Source: 1984 AACS.

R 460.18907
Source: 1988 AACS.

R 460.18909
Source: 1984 AACS.

R 460.18910
Source: 1984 AACS.

R 460.18911
Source: 1984 AACS.

R 460.18912
Source: 1984 AACS.

PART 10. COLLECTIVE RATE MAKING BETWEEN OR AMONG CARRIERS

R 460.19001
Source: 1984 AACS.

R 460.19002
Source: 1984 AACS.

R 460.19003
Source: 1984 AACS.

R 460.19004
Source: 1984 AACS.

R 460.19005
Source: 1984 AACS.

R 460.19006
Source: 1984 AACS.

R 460.19007
Source: 1984 AACS.

R 460.19008
Source: 1984 AACS.

R 460.19009
Source: 1984 AACS.

R 460.19010
Source: 1984 AACS.

R 460.19011
Source: 1984 AACS.

R 460.19012
Source: 1984 AACS.

R 460.19013
Source: 1984 AACS.

R 460.19014
Source: 1984 AACS.

R 460.19016
Source: 1984 AACS.

R 460.19018
Source: 1984 AACS.

R 460.19019
Source: 1988 AACS.

R 460.19020
Source: 1984 AACS.

R 460.19021
Source: 1984 AACS.

R 460.19022
Source: 1984 AACS.

PART 11. INSURANCE

R 460.19101
Source: 1984 AACS.

R 460.19102
Source: 1988 AACS.

R 460.19103
Source: 1984 AACS.

R 460.19104
Source: 1988 AACS.

R 460.19105
Source: 1988 AACS.

R 460.19106
Source: 1984 AACS.

PART 12. RATES AND TARIFFS

R 460.19201
Source: 1984 AACS.

R 460.19202
Source: 1984 AACS.

R 460.19203
Source: 1988 AACS.

R 460.19204
Source: 1984 AACS.

RATE JUSTIFICATION

R 460.19205
Source: 1984 AACS.

R 460.19206
Source: 1988 AACS.

R 460.19207
Source: 1984 AACS.

R 460.19209
Source: 1984 AACS.

R 460.19210
Source: 1984 AACS.

R 460.19211
Source: 1988 AACS.

R 460.19212
Source: 1984 AACS.

R 460.19213
Source: 1984 AACS.

R 460.19214
Source: 1984 AACS.

R 460.19215
Source: 1984 AACS.

R 460.19216
Source: 1984 AACS.

R 460.19217
Source: 1988 AACS.

R 460.19218
Source: 1984 AACS.

R 460.19219
Source: 1984 AACS.

R 460.19220
Source: 1984 AACS.

R 460.19221
Source: 1984 AACS.

R 460.19222
Source: 1984 AACS.

R 460.19223
Source: 1984 AACS.

R 460.19224
Source: 1984 AACS.

R 460.19225
Source: 1984 AACS.

R 460.19226
Source: 1984 AACS.

R 460.19227
Source: 1984 AACS.

R 460.19228
Source: 1984 AACS.

TARIFF COMPILATION

R 460.19229
Source: 1984 AACS.

R 460.19230
Source: 1984 AACS.

R 460.19231
Source: 1984 AACS.

R 460.19232
Source: 1984 AACS.

R 460.19233
Source: 1984 AACS.

R 460.19234
Source: 1988 AACS.

R 460.19235
Source: 1984 AACS.

R 460.19236
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R 460.19237
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R 460.19238
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R 460.19239
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R 460.19240
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R 460.19241
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R 460.19242
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R 460.19243
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R 460.19244
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R 460.19245
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R 460.19246
Source: 1988 AACS.

R 460.19247
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R 460.19248
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R 460.19249
Source: 1984 AACS.

R 460.19250
Source: 1988 AACS.

R 460.19251
Source: 1984 AACS.

R 460.19252
Source: 1984 AACS.

R 460.19253
Source: 1984 AACS.

PART 13. FORMS

R 460.19301
Source: 1988 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

PUBLIC SERVICE COMMISSION

GAS SAFETY

PART 1. GENERAL PROVISIONS

R 460.20101
Source: 1998-2000 AACS.

R 460.20102
Source: 1998-2000 AACS.

R 460.20103
Source: 1998-2000 AACS.

R 460.20104
Source: 1998-2000 AACS.

PART 2. SAFETY STANDARDS AND TESTING REQUIREMENTS

R 460.20201
Source: 2003 AACS.

R 460.20202
Source: 1998-2000 AACS.

PART 3. ADDITIONAL MINIMUM SAFETY STANDARDS

R 460.20401
Source: 2003 AACS.

R 460.20402
Source: 2003 AACS.

R 460.20403
Source: 2003 AACS.

R 460.20404
Source: 2003 AACS.

R 460.20405
Source: 2003 AACS.

R 460.20406
Source: 2003 AACS.

R 460.20407
Source: 2003 AACS.

R 460.20408
Source: 2003 AACS.

R 460.20409
Source: 2003 AACS.

R 460.20410
Source: 2003 AACS.

R 460.20411
Source: 2003 AACS.

R 460.20412
Source: 2003 AACS.

R 460.20413
Source: 2003 AACS.

R 460.20414
Source: 2003 AACS.

R 460.20415
Source: 2003 AACS.

R 460.20416
Source: 2003 AACS.

R 460.20417
Source: 2003 AACS.

R 460.20418
Source: 2003 AACS.

R 460.20419
Source: 2003 AACS.

R 460.20420
Source: 2003 AACS.

R 460.20421
Source: 2003 AACS.

R 460.20422
Source: 2003 AACS.

R 460.20423
Source: 2003 AACS.

R 460.20424
Source: 2003 AACS.

R 460.20425
Source: 2003 AACS.

R 460.20426
Source: 2003 AACS.

R 460.20427
Source: 2003 AACS.

R 460.20428
Source: 2003 AACS.

R 460.20429
Source: 2003 AACS.

R 460.20430
Source: 2003 AACS.

R 460.20431
Source: 2003 AACS.

PART 4. SOUR GAS PIPELINES

R 460.20401
Source: 1998-2000 AACS.

R 460.20402

Source: 1998-2000 AACS.

R 460.20403
Source: 1998-2000 AACS.

R 460.20404
Source: 1998-2000 AACS.

R 460.20405
Source: 1998-2000 AACS.

PART 5. RECORDS AND REPORTS

R 460.20501
Source: 1998-2000 AACS.

R 460.20502
Source: 2003 AACS.

R 460.20503
Source: 1998-2000 AACS.

R 460.20504
Source: 1998-2000 AACS.

PART 6. ADOPTION OF STANDARDS

R 460.20601
Source: 2003 AACS.

R 460.20602
Source: 2003 AACS.

R 460.20603
Source: 2003 AACS.

R 460.20604
Source: 2003 AACS.

R 460.20605
Source: 2003 AACS.

R 460.20606
Source: 2003 AACS.

DEPARTMENT OF TRANSPORTATION

BUREAU OF URBAN AND PUBLIC TRANSPORTATION

STATE RAIL LINE DIVESTITURE

R 474.51
Source: 1998-2000 AACS.

R 474.52
Source: 1998-2000 AACS.

R 474.53

Source: 1998-2000 AACS.

R 474.54
Source: 1998-2000 AACS.

R 474.55
Source: 1998-2000 AACS.

R 474.56
Source: 1998-2000 AACS.

R 474.57
Source: 1998-2000 AACS.

R 474.58
Source: 1998-2000 AACS.

R 474.59
Source: 1998-2000 AACS.

MOTOR BUS TRANSPORTATION

R 474.101
Source: 1985 AACS.

R 474.102
Source: 1985 AACS.

R 474.103
Source: 1985 AACS.

R 474.104
Source: 1985 AACS.

R 474.105
Source: 1985 AACS.

R 474.106
Source: 1985 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

PUBLIC SERVICE COMMISSION

TELECOMMUNICATION SERVICES

PART 1. GENERAL PROVISIONS

R 484.1 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.2 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

PART 2. RECORDS AND REPORTS

R 484.21 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.22 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.23 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.24 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

PART 3. CUSTOMER RELATIONS

R 484.31 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.32 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.33 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.34 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

PART 4. ENGINEERING

R 484.41 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.42 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.43 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.44 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

PART 5. MAINTENANCE

R 484.51 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.52 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.53 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.54 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

PART 6. QUALITY OF SERVICE

R 484.61 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.62 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.63 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.64 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.65 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.66 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

R 484.67 Rescinded.
History: 1996 MR 7, Eff. July 17, 1996; 2005 MR 11, Eff. June 14, 2005.

OPERATOR SERVICE PROVIDERS

R 484.101
Source: 1996 AACS.

R 484.102
Source: 1996 AACS.

R 484.103
Source: 1996 AACS.

R 484.104
Source: 1996 AACS.

R 484.105
Source: 1996 AACS.

R 484.106
Source: 1996 AACS.

R 484.107
Source: 1996 AACS.

R 484.108
Source: 1996 AACS.

R 484.109
Source: 1996 AACS.

R 484.110
Source: 1996 AACS.

R 484.111
Source: 1996 AACS.

R 484.112
Source: 1996 AACS.

PAYPHONE SERVICE

R 484.151

Source: 1996 AACS.

R 484.152
Source: 1996 AACS.

R 484.153
Source: 1996 AACS.

R 484.154
Source: 1996 AACS.

R 484.155
Source: 1996 AACS.

R 484.156
Source: 1996 AACS.

R 484.157
Source: 1996 AACS.

R 484.158
Source: 1996 AACS.

PRIVACY STANDARDS FOR TELECOMMUNICATION SERVICES

R 484.201
Source: 1996 AACS.

R 484.202
Source: 1996 AACS.

R 484.203
Source: 1996 AACS.

R 484.204
Source: 1996 AACS.

R 484.205
Source: 1996 AACS.

R 484.206
Source: 1996 AACS.

R 484.207
Source: 1996 AACS.

R 484.208
Source: 1996 AACS.

BILLING STANDARDS FOR BASIC RESIDENTIAL TELECOMMUNICATION SERVICE

PART 1. GENERAL PROVISIONS

R 484.301
Source: 1996 AACS.

R 484.302
Source: 1996 AACS.

R 484.303
Source: 1996 AACS.

PART 2. PROHIBITED ACTIVITIES

R 484.321
Source: 1996 AACS.

R 484.322
Source: 1996 AACS.

PART 3. BILLING AND PAYMENT STANDARDS

R 484.331
Source: 1996 AACS.

R 484.332
Source: 1996 AACS.

R 484.333
Source: 1996 AACS.

R 484.334
Source: 1996 AACS.

R 484.335
Source: 1996 AACS.

R 484.336
Source: 1996 AACS.

R 484.337
Source: 1996 AACS.

PART 4. SECURITY DEPOSITS, SERVICE OBLIGATIONS, AND PREPAYMENT OF SERVICES

R 484.341
Source: 1996 AACS.

R 484.342
Source: 1996 AACS.

PART 5. CUSTOMER ACCESS TO INFORMATION

R 484.351
Source: 1996 AACS.

R 484.352
Source: 1996 AACS.

R 484.353
Source: 1996 AACS.

PART 6. INVESTIGATIONS AND INFORMAL COMPLAINT PROCEDURES

R 484.361
Source: 1996 AACS.

R 484.362
Source: 1996 AACS.

PART 7. FORMAL COMPLAINTS

R 484.371
Source: 1996 AACS.

R 484.372
Source: 1996 AACS.

R 484.373
Source: 1996 AACS.

PART 8. SHUTOFF OF SERVICE

R 484.381
Source: 1996 AACS.

R 484.382
Source: 1996 AACS.

R 484.383
Source: 1996 AACS.

R 484.384
Source: 1996 AACS.

R 484.385
Source: 1996 AACS.

R 484.386
Source: 1996 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

PUBLIC SERVICE COMMISSION

TELECOMMUNICATION SERVICES

PART 1. GENERAL PROVISIONS

R 484.401 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.402 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

PART 2. RECORDS, REPORTS, AND TARIFFS

R 484.421 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.422 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.423 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.424 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.425 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

PART 3. CUSTOMER RELATIONS

R 484.431 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.434 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.435 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.438 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.439 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.440 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.440a Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.440b Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.440c Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

PART 4. ENGINEERING AND PLANNING

R 484.441 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.442 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.443 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.444 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.445 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.446 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

PART 5. REPAIR AND INSTALLATION

R 484.451 Rescinded.

History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.452 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.453 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.454 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.455 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.456 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.457 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.458 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.459 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

PART 6. MONITORING

R 484.460 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

R 484.461 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

PART 7. WAIVERS AND EXCEPTIONS

R 484.471 Rescinded.
History: 2003 MR 7, Eff. Aug. 1, 2003; rescinded 2005 MR 15, Eff. Aug. 5, 2005.

DEPARTMENT OF LABOR AND ECONOMIC GROWTH

DIRECTOR'S OFFICE

MICHIGAN CHILDREN'S PROTECTION REGISTRY RULES

R 484.501 Definitions.
Rule 1. As used in these rules:
(a) "Children's Protection Registry Fund" means a separate fund created in the state treasury to be administered by the department under section 4 of 2004 PA 241, MCL 752.1064. The fund shall serve as a repository for fees collected under section 3 of the Michigan Children's Protection Registry Act.
(b) "Cohort" means a logical grouping of minors represented by a group registrant. Uses of cohorts include, but are not limited to, schools choosing to register each graduating class with a designated birth year.
(c) "Contact point" means any electronic identification to which messages can be sent, including any of the following:
(i) An instant message identity.
(ii) A wireless telephone number.
(iii) A pager number.

(iv) A facsimile number.
(v) An electronic mail address.
(vi) Other electronic addresses subject to rules promulgated under 2004 PA 241, MCL 752.1063 by the department.
(d) “Department” means the Michigan department of labor and economic growth.
(e) "Digital media" means any magnetic or electronic storage device, including but not limited to, hard disks, floppy diskettes, backup media, CD-Roms, DVD-Roms, Zip disks, optical disks, printer buffers, smart cards, memory calculators, electronic dialers, Bernoulli drives, or electronic notebooks
(f) “Group registrant” means a school or other entity primarily serving minors who registers 1 or more contact points on behalf of its minor constituency.
(g) “Internet domain name” means a registered and easily identifiable alias for a globally unique, hierarchical numerical reference to an Internet host or service, assigned through centralized Internet authorities, comprising a series of character strings separated by periods.
(h) “Minor” means an individual under the age of 18 years.
(i) “Person” means an individual, corporation, association, partnership, or any other legal entity.
(j) “Prohibited message” means any message, whether direct or indirect, with the primary purpose of advertising or presenting, or otherwise linking to a message that advertises or presents, a product or service that a minor is prohibited by law from purchasing, viewing, possessing, participating in, or otherwise receiving. This includes, but is not limited to, sexually explicit materials, tobacco products, illegal drugs, gambling opportunities, and alcoholic beverages.
(k) “Protect MI Child Act” means the Michigan Children’s Protection Registry Act, 2004 PA 241, MCL 752.1061 to 752.1068.
(l) “Registry” or “Protect MI Child Registry” means the child protection registry created under section 3 of 2004 PA 241, MCL 752.1063.
(m) “Responsible party” means a parent, guardian, individual, or group registrant who is responsible for a contact point to which a minor may have access.
(n) “Sender” means any person who conveys, seeks to convey, or attempts to convey, directly or indirectly, a prohibited message.
(o) “State” means the state of Michigan.
(p) “Vendor” means a third-party administrator who operates the Protect MI Child Registry and related services under contract to the state of Michigan.
(q) “Website” means a particular company, user, or organization's HTML pages collectively accessible on the World Wide Web through a web server. A website is accessible through a unique Internet address or uniform resource locator (URL).
History: 2005 MR 9, Eff. July 1, 2005.

R 484.502 Accessibility of registry through secure website.
Rule 2. (a) All registrations, including amendments, renewals, and deletions related thereto, shall be made through 1 or more secure and encrypted websites to be established and operated by the department or under contract to the department.
(b) Transactions for both registrants and senders shall be accommodated through the department’s website.
History: 2005 MR 9, Eff. July 1, 2005.

R 484.503 Registrants.
Rule 3. A responsible party may register a contact point with the department under these rules.
History: 2005 MR 9, Eff. July 1, 2005.

R 484.504 Registration process and required information.
Rule 4. (1) A responsible party may register contact points by the following means:
(a) The preferred method of registration shall be through the department website.
(b) Group registrants may also register by other means as determined by the department.
(c) If a responsible party chooses to register using an alternative medium, which may include digital media, approved by the department, then the information that is submitted shall be entered into the department website for official registry.
(2) The following are required fields for information on minors submitted by individual registrants:
(a) The following fields for the following contact points shall be provided:
(i) Electronic mail address or addresses.
(ii) Telephone phone number or numbers including mobile, pager, and facsimile.
(iii) Instant message identity.
(iv) Other information required to adequately identify the contact point.
(b) Birth date.

(c) Submission date and time stamp.
(3) The following are required fields for information on the responsible party who submits an individual registration:
(a) Full name.
(b) Mailing address.
(c) Telephone number or numbers at which the party can be contacted.
(d) Electronic mail address.
(4) A responsible party may, as an individual registrant, submit entries for up to 15 children.
(5) The following are required fields for information on minors submitted by group registrants:
(a) Fields for the following contact points shall be provided:
(i) Electronic mail address or addresses.
(ii) Telephone phone number or numbers including mobile, pager, and facsimile.
(iii) Internet domain name if entire suffix is to be blocked.
(iv) Instant message identity.
(v) Other information required to adequately identify the contact point.
(b) Birth date or cohort year.
(c) Submission date and time stamp.
(6) The following are required fields for information on the responsible party who submits a group registration:
(a) Full name.
(b) Title.
(c) Organization name.
(d) Mailing address.
(e) Telephone numbers where the party may be contacted.
(f) Electronic mail address.
History: 2005 MR 9, Eff. July 1, 2005.

R 484.505 Tenure of registration.
Rule 5. Registered contact points shall be valid for 3 years, or until the year a minor or cohort turns 18, whichever comes sooner. The department may establish a shorter tenure of registration if necessary to improve registry operations or services.
History: 2005 MR 9, Eff. July 1, 2005.

R 484.506 Options for group registrants.
Rule 6. Group registrants may register 1 or more contact points with the department. Group registrants shall have all of the following options:
(a) Register individual contact points for all group members.
(b) Register an entire Internet domain name suffix.
(c) Register group members in cohorts.
History: 2005 MR 9, Eff. July 1, 2005.

R 484.507 Confirmation of registration.
Rule 7. (1) Before the registration is complete and entered into the database, a confirmation message shall be sent to the responsible party and contact points.
(2) The content of the confirmation message shall be determined by the department.
(3) Confirmation messages shall be sent via electronic mail whenever possible.
History: 2005 MR 9, Eff. July 1, 2005.

R 484.508 Renewals of registered contact points.
Rule 8. (1) The department shall offer a convenient process for renewals that provides for uninterrupted listing in the registry of contact points to which minors have access.
(2) The department may require that confirmation of renewals be provided to responsible parties and contact points.
(3) Responsible parties may renew their registrations through the same business channels offered for the original registration.
History: 2005 MR 9, Eff. July 1, 2005.

R 484.509 Amendments and deletions.
Rule 9. (1) Amendments to contact point or registrant information shall be accommodated upon request of the responsible party who initially requested registration of a contact point.
(2) Unless renewed, contact points shall automatically be deleted from the registry when the affected minor or cohort reaches

the age of 18, or after 3 years, whichever comes sooner.
(3) Early deletion of registered contact points shall be accommodated upon request of any of the following:
(a) The responsible party who initially requested registration of the contact point.
(b) The owner of an address that is erroneously listed as a contact point in the registry.
(c) The department based upon such additional criteria as it may establish.
History: 2005 MR 9, Eff. July 1, 2005.

R 484.510 Mechanism for verification of sender compliance.
Rule 10. (1) No sender or other person, except as designated by the department, may obtain access to the Protect MI Child Registry until payment is received.
(2) A sender shall verify compliance with the Protect MI Child Registry by comparing the lists of contact points for all those to whom the sender wishes to send prohibited messages through the secure system established by the department. The privacy of lists submitted by senders shall be taken into consideration by the department in establishing the configuration requirements for the verification system.
(3) Senders shall not use, sell, or disclose any list of registered contact points that they may be derived or obtained through use of the registry or by any other means.
(4) Both of the following apply to confirmation of sender subscription to registry:
(a) Senders shall be provided with confirmation of their subscription following acceptance of their payment.
(b) Senders shall receive informational materials regarding their obligations under the Protect MI Child Act with the confirmation of their subscription.
History: 2005 MR 9, Eff. July 1, 2005.

R 484.511 Fees.
Rule 11. (1) A registry sign-up fee or charge shall not be assessed to a person registering a contact point with the department.
(2) Both of the following apply to a registry access fee:
(a) Senders shall be charged a fee to access the registry.
(b) The vendor creating the registry system shall propose a fee schedule. That fee schedule shall not exceed 3 cents per contact point checked against the registry, for each time a contact point is checked against the registry. In determining the appropriate fee schedule, the department shall judge vendor submissions which encourage the largest number of compliant senders.
History: 2005 MR 9, Eff. July 1, 2005.

R 484.512 Revenue collection.
Rule 12. (1) The department shall establish and administer a revenue account in the state treasury for the Children's Protection Registry Fund, in accordance with section 4 of the Protect MI Child Act.
(2) The department shall determine revenue collection form and arrangements. The revenue collection process may be limited to electronic transactions.
History: 2005 MR 9, Eff. July 1, 2005.

DEPARTMENT OF LABOR AND ECONOMIC GROWTH

PUBLIC SERVICE COMMISSION

TELECOMMUNICATION SERVICES

PART 1.GENERAL PROVISIONS

R 484.519 Applicability.
Rule 1. These rules apply to telecommunication services regulated by the commission.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.520 Definitions.
Rule 2.(1)As used in these rules:
(a)"Act" means 1991 PA 179, MCL 484.2101 et seq.
(b)"Answer" means that a provider's representative, voice response unit, or automated operator system is ready to render

assistance or ready to accept information necessary to process a call.
(c)"Average busy season, busy hour traffic" means the average traffic volume for the busy season, busy hour.
(d) "Business day" means those days on which the provider's offices are open for business.
(e)"Busy hour" means the hour when a telecommunication switching system carries the greatest volume of traffic. The busy hour is typically the busiest hour of the busiest day of a normal week.
(f)"Busy season" means the period of the year during which a telecommunication switching system carries the greatest volume of traffic.
(g)"Call" means the action by a customer to obtain a telephone connection whether the connection is completed or not.
(h)"Central office" means a switching unit in a telecommunication system which provides service to the general public, and which has the necessary equipment and operating arrangements for terminating and interconnecting customer lines and trunks or trunks only.
(i)"Commission" means the Michigan public service commission.
(j)"Customer" means any person, firm, partnership, corporation, municipality, cooperative, organization, or governmental agency using regulated telecommunication services furnished by a provider.
(k)"Customer trouble report" means any oral or written report from a customer relating to a physical defect, difficulty, or dissatisfaction with the operation or facilities of a provider.
(l)"Emergency" means the loss of service to any of the following entities:
(i) A hospital, medical care facility, or any other facility providing health or public safety services.
(ii)An employee of a public safety, emergency medical, or professional trade who is on call during the service loss and has so advised the provider.
(iii)A person who has a medical need that is life-threatening and has so advised the provider.
(iv) A school while in regular class session.
(v)An adult care facility.
(vi) A child care facility during business hours.
(m) "Facilities-based provider" means a telecommunication provider that provides basic local exchange service to end user customers by means of network facilities that it owns or controls. Where the term facilities-based provider is used throughout these rules, the rules hall only apply to a provider to the extent that the rule applies to the
network facilities that the provider user owns or controls and uses to
provision service to the affected end-user.
(n)"Installation" means the provision of service to the provider's interface device or equivalent equipment.
(o)"Out of service "means a condition of a customer's telecommunication service that prevents the customer from either making or receiving calls.
(p)"Provider" means a person, firm, partnership, corporation, or other entity that provides basic local exchange service as defined by section 102(b) of the act.
(q) "Small business customer" means a business whichhas20 or fewer access lines.
(r)"Tariff "means the compilation of all rates, charges, classifications, and rules adopted by a provider and filed with the commission.
(s)"Traffic" means telephone call volume, based on the number and duration of messages.
(2)A term defined in the act has the same meaning when used in these rules.
History: 2005 MR 15, Eff. Aug 5, 2005.

PART 2. RECORDS, REPORTS, AND TARIFFS

R 484.521 Availability of records.

Rule 21. (1) A provider shall make available to the commission or its staff, upon request, all records, reports, and other information required to determine compliance with these rules and to permit the commission and its staff to investigate and resolve quality of service issues related to regulated telecommunication services.
(2) A provider shall make records, reports, and other information available to the commission or its staff in 5 business days, preferably in an electronic format which is available through the internet and which is accessible with standard browser software, identification, and password, or as soon thereafter as feasible.
(3) Records constituting or incorporating trade secrets or commercial or financial information that are made available to the commission or its staff may be made exempt from disclosure pursuant to section 210 of the act.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.522 Retention of records.

Rule 22. A provider shall preserve, in detail, all records required by these rules for the immediate past 12 months, and shall

preserve, in summary form, all records for not less than 3 years, unless otherwise ordered by the commission.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.523 Reports of service disruptions.
Rule 23. (1) A facilities-based provider shall report promptly to the commission any specific occurrence on its network that disrupts service to a substantial number of customers or that may impair its ability to furnish service to a substantial number of customers. A facilities-based provider shall report all disruptions that affect the lesser of 25% or 2,000 of the access lines in any exchange for 1 hour or more. It shall notify the commission and post the disruption information on the provider's internet website, if the provider has an internet website, within 90 minutes of becoming aware of the disruption during normal business hours, or, if the disruption occurs during the evening or a weekend, within 90 minutes of the commencement of the next business day.The facilities-based provider shall also notify other providers dependent on the facilities-based provider's network within 90 minutes of becoming aware of the occurrence, unless interconnection agreements specify other notice requirements.
(2) A facilities-based provider shall file a final report with the commission in electronic form within 30 days of any service disruption subject to subrule (1) of this rule. The report shall contain all of the following information:
(a) The reason for the disruption.
(b) The geographic area affected.
(c) The number of customers affected.
(d) The type of services affected.
(e) The effect upon the provider.
(f) Whether the service disruption was avoidable.
(g) An explanation of the provider's remedy for the service disruption.
(h) A description of the actions that the provider has taken or could take to avoid similar disruptions in the future.
(3) The reports submitted to the commission under subrules (1) and (2) of this rule shall be deemed to contain confidential information within the meaning of Section 210 of the Act and shall be exempt from the freedom of information act, 1976 PA 442.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.524 Service measurements.
Rule 24. Upon request of the commission or its staff, a provider shall make measurements to determine the level of its compliance with these rules.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.525 Tariffs.
Rule 25. A provider shall file its tariff with the commission in accordance with applicable laws and commission orders governing the filing of tariffs. A provider's bills and telephone directories shall prominently display an internet URL address at which its tariff is available or a phone number to call for information.
History: 2005 MR 15, Eff. Aug 5, 2005.

PART 3. CUSTOMER RELATIONS

R 484.531 Rate and special charges information.
Rule 31. (1) Upon the request of a customer or an applicant for service, a provider shall explain the rates, charges, and provisions under which it provides service and shall provide a copy of the applicable tariff section or pages for the regulated telecommunication services. This requirement may be satisfied by referring a customer to an internet website containing tariffs if the customer states he or she has access.
(2) A provider shall furnish reasonable access to information and assistance necessary to enable the customer or applicant to obtain the most economical service available to meet the customer's or applicant's stated needs, including state or federal "lifeline" programs that may be available.The provider shall advise the customer or applicant about any of the provider's alternative services that are available to meet those needs. The information may include printed explanations of alternative services and rates.
(3) Before changing or installing a service, a provider shall furnish the customer or applicant with an estimate of the amount of any service connection charges and an estimate of the initial bill for basic monthly service and any other applicable charges.
(4) Upon request, a provider shall furnish the customer or applicant with a written, detailed estimate of any special charges not specifically set forth in the provider's tariff. Special charges include any of the following:

(a) Extraordinary construction, maintenance, and replacement costs.
(b) Expenses for overtime work at the customer's or applicant's request.
(c) Special installations, equipment, and assemblies.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.534 Public information.
Rule 34. (1) A provider shall make available to a customer or applicant all of the following information on a website or shall provide copies upon request:
(a) Maps or npa-nxx data showing local calling areas and zone boundaries.
(b) Publicly announced information as to the availability of specific classes of service at a customer's or applicant's location.
(c) Publicly announced information concerning plans for major service changes at a customer's or applicant's location.
(2) A provider shall advise a customer if the customer is located in an area in which the dialing of a 7- or 10-digit number may result in toll charges.
(3) A provider shall prominently display on its bills and other messages to its customers the provider's phone numbers to be used for customer inquiries, disputes, repairs, and other contacts.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.535 Business offices.
Rule 35. (1) A provider shall maintain business offices that are adequately staffed with qualified persons to do all of the following:
(a) Provide information relating to its services and rates.
(b) Accept and process applications for service.
(c) Explain charges on bills.
(d) Adjust erroneous charges.
(e) Enter into payment arrangements.
(f) Act as a representative of the provider.
(2) A provider shall maintain a local or toll-free telephone number by which all customers served by a business office may call that office at no charge.
(3) A provider shall maintain sufficient staffing to ensure that customers and others who call a business office are permitted to talk to a person who is able to provide assistance within a monthly average of 120 seconds of calling the office during normal business hours.
(4) A provider shall ensure that all information provided to customers and others is accurate and in compliance with commission rules and the provider's tariff. A provider shall not make a statement to a customer that the provider knows to be untrue.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.538 Advertising.
Rule 38. If a regulated service is not generally available, then a provider's advertising of that service without clearly disclosing the limits on its availability is false, misleading, or deceptive within the meaning of section 502(1)(a) of the act.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.539 Directories.
Rule 39. (1) A provider shall furnish to new customers and annually to existing customers, at no additional charge, an up-to-date telephone directory for the customer's area unless the provider and customer agree otherwise.
(2) If a provider publishes a directory, the provider shall furnish a copy to the commission.
(3) The front cover of each directory shall indicate the area included in the directory and the month and year of issue. The front portion of the directory shall conspicuously feature information about placing calls to emergency services, police and fire departments, 9-1-1 service, 2-1-1 service, and dual party relay service.
(4) Each directory shall contain instructions concerning all of the following:
(a) Placing of local and long-distance calls.
(b) Obtaining repair and directory assistance services.
(c) The locations and telephone numbers of the provider's business office or offices for the area served by the directory.
(d) The means to determine which numbers are in the local calling area.

History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.540 Directory errors, omissions, and changes.
Rule 40. (1) If an error in the listed number of a customer occurs, and the error resides in the provider's switch, then the provider shall intercept all calls to the listed number for the remaining life of the directory, if the existing central office equipment permits it to do so and the number is not in service for another customer.
(2) If an error or omission in the name listing of a customer occurs, then the provider shall include the customer's correct name and telephone number in the files of the directory assistance and intercept operators.
(3) If a customer's telephone number is changed, then the provider shall intercept all calls to the previous number for a minimum of 3 months and give the calling party the new number unless the previous number has been reassigned, the customer has denied permission, or equipment limitations prevent the intercept.
(4) If additions or changes to plant or any other operations necessitate changing telephone numbers assigned to a group of customers, then a provider shall give reasonable notice to all customers affected, even though the change in numbers may coincide with the issuance of a directory.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.540a Directory assistance and intercept calls.
Rule 40a. (1) Directory assistance operators shall have access to all telephone numbers for the area for which they are responsible for furnishing directory assistance service, except telephone numbers not listed or published at the customer's request.
(2) If a provider's directory assistance operator provides an incorrect number, then the provider shall not bill for the call or shall give a credit equal to the charge and the provider shall not count the call against the customer's monthly call allowance.
(3) A provider shall furnish a customer up to 2 numbers per call to directory assistance.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.540b Operator services.
Rule 40b. A provider shall assure that operators answer calls within a monthly average of 10 seconds. An acknowledgment that the customer is waiting on the line is not an answer.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.540c Complaints and appeals.
Rule 40c. (1) Within 10 business days after receiving an oral or written complaint from a customer or applicant, a provider shall investigate and respond fully and promptly unless an extension of time is requested and granted by the complainant. A provider shall notify the customer or applicant of its proposed disposition of the complaint after having made a good faith attempt to resolve the complaint. Upon request by the customer or applicant, a provider shall furnish its proposed disposition of the complaint in writing.
(2) A provider shall prominently include, on all of its bills and in each telephone directory, the telephone number to which a customer or applicant can make inquiries and direct a complaint. The provider shall provide a mailing address upon request and shall include a distinctive entity or person designated by the company to receive written complaints.
(3) A provider shall require its personnel to provide upon request any complaint escalation procedures and the name, address, and telephone number of the commission for further review of an unresolved problem.
(4) Upon receipt of a complaint, whether oral or written, from the commission or its staff, a provider shall do all of the following:
(a) If necessary, attempt to contact the affected customer within 2 business days.
(b) Promptly investigate the complaint and report the results of its investigation.
(c) Provide a final response to the commission or its staff within 10 business days, unless an extension is requested and granted by the commission staff.
(5) Failure to respond to a customer, applicant, commission, or commission staff within 30 days of a complaint, unless an extension is granted, shall create a presumption that the complaint is valid.
History: 2005 MR 15, Eff. Aug 5, 2005.

PART 4. ENGINEERING AND PLANNING

R 484.541 Construction.

Rule 41. (1) A provider shall design, engineer, construct, maintain, and operate its telecommunication plant and facilities as a reasonably prudent provider would and in compliance with R 460.813, except as may be modified by the commission. A provider shall comply with these requirements in the manner that best accommodates the public and prevents, to the extent practical, interference with and from services furnished by other telecommunication service providers and public utilities.
(2) A provider shall design its telecommunication plant as a reasonably prudent provider would so as to prevent electromagnetic interference from alternating current power systems. A provider shall engage in prior coordination with an electric utility before placing new plant or making major changes in existing plant likely to be affected by the electric utility's facilities.
(3) To minimize the occurrence of voltage and grounding problems, a provider shall consult and coordinate with existing electric and natural gas utilities in the general vicinity of planned telecommunication plant construction before construction.
(4) A provider shall comply with the provisions of 1974 PA 53, MCL 460.701 et seq.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.542 General practices.
Rule 42. (1) A provider shall employ prudent management and engineering practices, including the use of reliable procedures for forecasting future demand for services. It shall conduct studies and maintain records to determine whether regulated telecommunication services will comply with these rules.
(2) A provider shall make traffic studies and maintain records as required to determine if sufficient equipment and an adequate operating force are provided at all times, including the average busy hour, busy season.
(3) A provider shall install sufficient central office capacity and equipment to permit customers to obtain dial tone within 3 seconds 98.5% of the time and complete not less than 99% of dialed calls without encountering an equipment blockage or irregularity.
(4) A provider shall engineer, construct, and maintain the trunk and related switching components in the provider's network that connect to the switched access network so that not less than 99% of properly dialed switched access calls (outgoing trunks) during the average busy season do not encounter equipment blockage or irregularity.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.543 Customer line transmission requirements.
Rule 43. A provider shall comply with all of the following standards for all customer loops at the network interface device:
(a) A circuit loss of less than 10.5 decibels measured to a milliwatt reference.
(b) A circuit current of 20 milliamperes or more.
(c) A circuit noise level of less than 30 decibels-reference noise calibration.
(d) A power influence level of less than 90 decibels-reference noise calibration.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.544 Intralata trunk transmission requirements.
Rule 44. A facilities-based provider shall comply with both of the following standards for all intralata trunks:
(a) Interoffice trunks shall have an objective of +/- 3.6 decibels of the engineered measured loss.
(b) End office to end office testing shall have an objective of +/- 3.6 decibels per switched leg of the engineered measured loss.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.545 Inspections and tests.
Rule 45. (1) A facilities-based provider shall adopt and implement a written program, including, but not limited to, periodic and routine testing and inspection of all of the following:
(a) Interoffice trunking, before and after being placed in service.
(b) Central office switching equipment connections.
(c) A sample of customer loops in each exchange.
(2) The written program shall be developed so as to achieve an efficient operation of the provider's system and the rendering of safe, adequate, and continuous service for both routine testing and inspection activities and for the testing and inspection of trouble locations.
(3) A facilities-based provider shall maintain, or have access to, test facilities enabling it to determine the operating and transmission capabilities of all equipment and facilities specified in subrule (1) of this rule.

History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.546 Emergency operation.
Rule 46. (1) A facilities-based provider shall make reasonable provision to provide service notwithstanding emergency power interruptions, unusual and prolonged increases in traffic, illness of its personnel, and fires, storms, or other emergencies. It shall inform its employees of the procedures to be followed for an emergency to prevent or minimize interruption and impairment of telecommunication service.
(2) A facilities-based provider shall equip each central office, remote switch, remote line unit, and interexchange toll switching office or access tandem with a minimum of 3 hours of peak load battery reserve, if permanent auxiliary power is installed, and 5 hours of battery reserve, if permanent emergency power is not installed, or 8 hours of battery reserve if the central office is in a remote location. It shall have available a mobile power unit to be delivered and connected to central offices, remote switches, and remote line units within 8 hours.
(3) A provider shall maintain current, written emergency procedures that are directed to the prompt restoration of telecommunication service during abnormal conditions.
(4) A 9-1-1 service supplier shall provide 24-hour, 7-day-a-week data base access so as to permit information to be acquired or corrected.
(5) A provider, 9-1-1 service supplier, public safety answering point, or any entity providing or maintaining 9-1-1 data base information shall correct each error in the 9-1-1 system or data base within 1 business day.
History: 2005 MR 15, Eff. Aug 5, 2005.

PART 5. REPAIR AND INSTALLATION

R 484.551 Maintenance of plant and equipment.
Rule 51. (1) A facilities-based provider shall adopt and implement maintenance program designed to achieve efficient operation of its system consistent with the rendering of safe, adequate, and continuous service in compliance with applicable codes.
(2) A facilities-based provider shall test, as needed, and maintain all plant and equipment up to and including the network interface device at the customer's location in safe and serviceable repair at no charge to the customer beyond the normal monthly charge for basic local exchange service.
A facilities-based provider shall do at least all of the following:
(a) Repair or replace broken, damaged, or deteriorated parts.
(b) Readjust adjustable apparatus and equipment when found to be in unsatisfactory operating condition.
(c) Correct electrical faults, such as leakage or poor insulation, noise induction, cross talk, or poor transmission characteristics.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.552 Customer trouble reports.
Rule 52. A facilities-based provider shall maintain service so that the average monthly rate of all customer trouble reports does not exceed 4 per 100 access lines, excluding reports concerning interexchange calls and trouble found in equipment other than the provider's equipment, such as inside wiring and customer premises equipment.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.553 Customer repair requests.
Rule 53. (1) A provider shall make provision for the receipt of customer repair requests at all hours. A provider shall maintain adequate personnel to answer customer repair calls within a monthly average of 25 seconds. An acknowledgment that the customer is waiting on the line is not an answer.
(2) A provider shall arrange to have a representative available at all times to accept calls from providers and users of 9-1-1 and emergency services to report trouble with its telecommunication services to those providers.
(3) A provider shall make a full and prompt investigation of all repair requests and shall render reasonable assistance to the customer to identify a cause for the outage that may be corrected by the customer.
(4) A provider shall maintain an accurate record of repair requests by telephone number or circuit number, as appropriate. The record shall include all of the following information:
(a) The customer or service affected.
(b) The time, date, and nature of the repair request.
(c) The action taken to clear the repair request or satisfy the complaint.
(d) The date and time the repair was completed or the request was otherwise closed.

(5) Until the customer indicates satisfaction of the request, a provider shall not attempt to market new services to a customer calling to report a repair request, unless such services would assist in resolving the problem.This subrule shall not become effective until June 30, 2008.
(6) If access to a customer's premises is necessary to complete the repair and the customer is not available, then a tag shall be left on the customer's door indicating the date, an explanation of the repair problem necessitating entry into the customer's premises, and the technician's name and signature.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.554 Emergency repairs.
Rule 54. (1) A provider shall attempt to clear all emergency out-of-service trouble within 4 hours after being reported to or found by the provider, except in any of the following situations:
(a) The safety of the provider's personnel would be at risk.
(b) Access to the customer's premises is required but not available.
(c) The repair is necessitated by an unavoidable occurrence affecting a large number of customers.
(d) The repair is technically infeasible to accomplish.
(2) A provider shall expedite a repair for a customer who has a medical emergency. Unless it has a specific, identifiable reason to doubt a customer's claim, a provider shall accept the customer's statement there is a medical condition requiring expedited restoration of service.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.555 Out-of-service repairs.
Rule 55. (1) A provider shall arrange to clear all out-of-service trouble of a nonemergency nature within the following time frames, unless the customer agrees to alternative arrangements:
(a) Out-of-service trouble shall be cleared within a monthly average of 36 hours after being reported to or found by the provider.
(b) The same repeat out-of-service trouble reported or found within 30 days of a prior repair shall be repaired the same or next business day after being reported to or found by the provider and identified as a repeat trouble.
(2) For the second and third days of an out-of-service incident, a provider shall give a residential or small business customer a credit equal to 1/30 of the customer's monthly charge for basic local exchange service for each day or portion of each day, commencing when the out-of-service trouble is reported to or found by the provider, until service is restored. After the third day, a provider shall give the customer a credit of $5.00 per day for the fourth and succeeding days until service is restored. This subrule shall not become effective until June 30, 2008.
(3) For the same repeat trouble within 30 days of the first occurrence, a provider shall give a residential or small business customer a credit of $5.00 for each day or portion of each day, commencing when the repeat trouble is reported to or found by the provider, until service is restored. This subrule shall not become effective until June 30, 2008.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.556 Other repairs.
Rule 56. A provider shall arrange to clear trouble that does not involve an emergency or out-of-service condition within a monthly average of 36 hours after being reported to or found by the provider.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.557 Repair appointments and commitments.
Rule 57. (1) For all repair requests requiring a customer to be present, a provider shall give a residential or small business customer a 4-hour time period within which the repair will commence. Otherwise, the commitments will specify a 24-hour period.
(2) For appointments scheduled at least 48 hours in advance, a provider shall keep all repair commitments unless it contacts the customer not less than 24 hours in advance and reschedules the appointment or commitment. If unusual repairs are required or other factors preclude completing repairs promptly, then a provider shall make reasonable efforts to notify the customer.
(3) If a provider misses a time commitment and subrule (2) of this rule does not apply, then the provider shall give the customer a credit of $25.00 for each missed commitment. This subrule shall not become effective until June 30, 2008.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.558 Installation commitments.
Rule 58. (1) A provider shall install service for a residential or small business customer or applicant within a monthly

average of 5 business days of the installation request, or a monthly average of 10 business days after a customer is released for a migration, unless a later date is requested or agreed to by the customer or applicant, the customer or applicant misses the appointment, or government permits or right-of-way access are required before installation.
(2) For basic local exchange service, a provider shall release the loop facilities and telephone number serving its customer within a monthly average of 5 business days after a request is made by a customer or on behalf of a customer to change local service providers.
(3) A provider shall keep records of all installations not completed by the commitment date.
(4) If a provider does not complete an installation by the fifth day, tenth day for a migration, or commitment date, then the provider shall waive 50% of the installation fee, unless the customer or applicant misses the appointment. If a provider does not complete an installation by the eleventh day, then the provider shall waive 100% of the installation fee, unless the customer or applicant misses the appointment. This subrule shall not become effective until June 30, 2008.
(5) A provider shall provide for the reclassification of service at the request of a customer not later than the date mutually agreed to between the provider and the customer. A provider shall report to the commission orders for reclassification of service being held more than 60 days.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.559 Return calls.
Rule 59. A provider shall return a call to a customer if the provider's representative tells the customer to expect a return phone call.
History: 2005 MR 15, Eff. Aug 5, 2005.

R 484.560 Planned service interruptions.
Rule 60. If a provider must interrupt service to work on lines or equipment, then it shall arrange to do the work in a manner that will cause minimal inconvenience to its customers. If the provider reasonably expects that service will be interrupted for more than 15 minutes, then the provider shall attempt to notify each affected customer, including wholesale customers, in advance of the interruption. The provider shall make emergency service available, as required, for the duration of the interruption.

PART 6. MONITORING

R 484.561 Key measures of performance.
Rule 61. (1) A provider shall compile information on all of the following performance measures:
(a) Completing the investigation and contacting the customer within monthly average of 10 days of the receipt of a complaint.
(b) Restoring service in a monthly average of 36 hours of the receipt of a trouble report.
(c) Answering calls to a business office in a monthly average of 120 seconds.
(d) Answering calls to a repair office in a monthly average of 25 seconds.
(e) Meeting new installation commitments within a monthly average of 5 business days.
(f) An average monthly rate of customer trouble reports of more than 4%.
(2) If a provider fails to meet any of the measures specified in subrule
(1) of this rule for 2 consecutive months, then the provider shall file a performance measure report and a remedial plan with the commission.
(3) The provider shall develop the format of the report in consultation with the commission staff.
History: 2005 MR 15, Eff. Aug 5, 2005.History: 2005 MR 15, Eff. Aug 5, 2005.

PART 7. WAIVERS AND EXCEPTIONS

R 484.571 Waivers and exceptions.
Rule 71. (1) A provider may petition for a permanent or temporary waiver or exception from these rules when specific circumstances beyond the control of the provider render compliance impossible or when compliance would be unduly economically burdensome or technologically infeasible.
(2) A provider may request a temporary waiver in order to have sufficient time to implement procedures and systems to comply with these rules.
(3) A provider may request a waiver or exception from some or all of these rules if it has obtained a competitive service classification from the commission pursuant to section 208 of the act.
(4) A provider shall be exempt from the provisions of these rules related to directory assistance to the extent the

commission determines that the service is competitive under section 207 of the act.
(5) A provider is exempt from R 484.555, R 484.557, R 484.558, or R 484.559 under any of the following circumstances:
(a) The problem is or was caused by the customer.
(b) The problem is or was attributable to an "act of God." The term "act of God" shall include events such as any of the following:
(i) Flood.
(ii) Lightning.
(iii) Tornado.
(iv) Earthquake.
(v) Fire.
(vi) Blizzard.
(vii) Ice storm.
(viii) Other unusual natural or man-made disasters.
(c) There is a work stoppage or other work action by the provider's (or underlying provider's) employees, beyond the control of the provider, that causes or caused a significant reduction in employee hours worked.
(d) The problem occurs or occurred during a major failure. A "major failure" is a single event or occurrence that is not the direct result of action taken by the provider and that generates out-of-service reports affecting 100 or more access lines.
(6) The provider shall notify the commission, in writing, within 10 business days of its intent to invoke the occurrence of an event described in subrule
(5) of this rule. The notification to the commission shall include all of the following information:
(a) Specific description of the event and general impact.
(b) Date or dates of the event.
(c) Location affected, such as exchanges or wire centers.
(d) Estimated number of customers affected.The commission staff shall have 10 business days following the notification to advise the provider, in writing, if it disputes the validity of the invocation of an event described in subrule (5) of this rule and the reasons for such dispute. If the dispute cannot be resolved within 10 business days of the commission staff's advice, then the provider shall file an application with the commission within 10 business days thereafter for resolution of the dispute.
History: 2005 MR 15, Eff. Aug 5, 2005.

FINANCIAL INSTITUTIONS BUREAU

APPRAISALS FOR REAL ESTATE LOANS

R 487.41
Source: 1997 AACS.

R 487.42
Source: 1997 AACS.

R 487.43
Source: 1997 AACS.

SMALL LOAN LICENSEES

R 487.71
Source: 1997 AACS.

R 487.72
Source: 1997 AACS.

R 487.73
Source: 1997 AACS.

R 487.74
Source: 1997 AACS.

R 487.75
Source: 1997 AACS.

R 487.76
Source: 1997 AACS.

R 487.77
Source: 1997 AACS.

R 487.78
Source: 1997 AACS.

R 487.79
Source: 1997 AACS.

R 487.80
Source: 1997 AACS.

R 487.81
Source: 1997 AACS.

R 487.82
Source: 1997 AACS.

R 487.83
Source: 1997 AACS.

R 487.84
Source: 1997 AACS.

R 487.85
Source: 1997 AACS.

R 487.86
Source: 1997 AACS.

R 487.87
Source: 1997 AACS.

R 487.88
Source: 1997 AACS.

R 487.89
Source: 1997 AACS.

R 487.90
Source: 1997 AACS.

R 487.91
Source: 1997 AACS.

INTEREST ON DEMAND DEPOSITS

R 487.111
Source: 1997 AACS.

HEARINGS

R 487.121
Source: 1997 AACS.

R 487.122
Source: 1997 AACS.

R 487.123
Source: 1997 AACS.

R 487.124
Source: 1997 AACS.

R 487.125
Source: 1997 AACS.

R 487.126
Source: 1997 AACS.

APPLICATION PROCEDURE FOR CHARTER, LICENSE, AND OTHER GRANTS OF AUTHORITY

R 487.201
Source: 1997 AACS.

R 487.202
Source: 1997 AACS.

R 487.203
Source: 1997 AACS.

R 487.204
Source: 1997 AACS.

R 487.205
Source: 1997 AACS.

R 487.206
Source: 1997 AACS.

R 487.207
Source: 1997 AACS.

R 487.208
Source: 1997 AACS.

R 487.209
Source: 1997 AACS.

COMMENT ON OR PETITION FOR PROMULGATION, AMENDMENT, OR RESCISSION OF RULES

R 487.251
Source: 1997 AACS.

R 487.252

Source: 1997 AACS.

R 487.253
Source: 1997 AACS.

R 487.254
Source: 1997 AACS.

R 487.255
Source: 1997 AACS.

R 487.256
Source: 1997 AACS.

BANKS

PART 1. GENERAL PROVISIONS

R 487.601
Source: 1997 AACS.

R 487.602
Source: 1997 AACS.

R 487.603
Source: 1997 AACS.

R 487.604
Source: 1997 AACS.

R 487.605
Source: 1997 AACS.

R 487.606
Source: 1997 AACS.

R 487.607
Source: 1997 AACS.

R 487.608
Source: 1997 AACS.

R 487.609
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R 487.610
Source: 1997 AACS.

R 487.611
Source: 1997 AACS.

R 487.612
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R 487.613
Source: 1997 AACS.

R 487.614
Source: 1997 AACS.

R 487.615
Source: 1997 AACS.

R 487.616
Source: 1997 AACS.

R 487.617
Source: 1997 AACS.

R 487.618
Source: 1997 AACS.

R 487.619
Source: 1997 AACS.

PART 4. PURCHASE OF INVESTMENT SECURITIES

R 487.641
Source: 1997 AACS.

R 487.642
Source: 1997 AACS.

R 487.643
Source: 1997 AACS.

R 487.644
Source: 1997 AACS.

R 487.645
Source: 1997 AACS.

R 487.646
Source: 1997 AACS.

R 487.647
Source: 1997 AACS.

R 487.648
Source: 1997 AACS.

R 487.649
Source: 1997 AACS.

R 487.650
Source: 1997 AACS.

R 487.651
Source: 1997 AACS.

PART 6. LOANS TO EXECUTIVE OFFICERS

R 487.671
Source: 1997 AACS.

R 487.672
Source: 1997 AACS.

R 487.673
Source: 1997 AACS.

R 487.674
Source: 1997 AACS.

PART 8. DEPOSIT OF SECURITIES WITH STATE TREASURER AS SECURITY FOR TRUST CREDITORS

R 487.691
Source: 1997 AACS.

R 487.692
Source: 1997 AACS.

R 487.693
Source: 1997 AACS.

COLLECTIVE INVESTMENT OF FIDUCIARY FUNDS

R 487.901
Source: 1997 AACS.

R 487.902
Source: 1997 AACS.

R 487.903
Source: 1997 AACS.

R 487.904
Source: 1997 AACS.

R 487.905
Source: 1997 AACS.

R 487.906
Source: 1997 AACS.

R 487.907
Source: 1997 AACS.

R 487.908
Source: 1997 AACS.

R 487.909
Source: 1997 AACS.

R 487.910
Source: 1997 AACS.

R 487.911
Source: 1997 AACS.

R 487.912
Source: 1997 AACS.

R 487.913
Source: 1997 AACS.

R 487.914
Source: 1997 AACS.

R 487.915
Source: 1997 AACS.

BANKS

PART 1. GENERAL PROVISIONS

R 487.1101
Source: 1998-2000 AACS.

R 487.1102
Source: 1998-2000 AACS.

PART 2. ADMINISTRATION

R 487.1201
Source: 1998-2000 AACS.

R 487.1202
Source: 1998-2000 AACS.

R 487.1203
Source: 1998-2000 AACS.

R 487.1204
Source: 1998-2000 AACS.

R 487.1210
Source: 1998-2000 AACS.

PART 4. POWERS

R 487.1410
Source: 1998-2000 AACS.

R 487.1420
Source: 1998-2000 AACS.

R 487.1421
Source: 1998-2000 AACS.

R 487.1422
Source: 1998-2000 AACS.

R 487.1423
Source: 1998-2000 AACS.

R 487.1424
Source: 1998-2000 AACS.

R 487.1425
Source: 1998-2000 AACS.

R 487.1426
Source: 1998-2000 AACS.

R 487.1427
Source: 1998-2000 AACS.

R 487.1430
Source: 1998-2000 AACS.

PART 5. REGULATION

R 487.1501
Source: 1998-2000 AACS.

R 487.1502
Source: 1998-2000 AACS.

R 487.1503
Source: 1998-2000 AACS.

PART 8. RESCISSION

R 487.1801
Source: 1982 AACS.

DEPARTMENT OF TREASURY

BUREAU OF MANAGEMENT SERVICES

STATE DIRECT DEPOSIT PROCESS

R 487.2101
Source: 1994 AACS.

R 487.2102
Source: 1994 AACS.

R 487.2103
Source: 1994 AACS.

R 487.2104
Source: 1994 AACS.

R 487.2105
Source: 1994 AACS.

R 487.2106
Source: 1994 AACS.

R 487.2107
Source: 1994 AACS.

R 487.2108
Source: 1994 AACS.

R 487.2109
Source: 1994 AACS.

R 487.2110
Source: 1994 AACS.

DEPARTMENT OF CONSUMER AND INDUSTRY SERVICES

FINANCIAL INSTITUTIONS BUREAU

SAVINGS AND LOAN ASSOCIATIONS

R 489.545—R 489.812
Source: 1997 AACS.

R 489.781.1
Source: 1997 AACS.

R 489.781.2
Source: 1997 AACS.

R 489.781.3
Source: 1997 AACS.

R 489.781.4
Source: 1997 AACS.

R 489.781.5
Source: 1997 AACS.

R 489.781.6
Source: 1997 AACS.

R 489.781.7
Source: 1997 AACS.

R 489.810
Source: 1997 AACS.

R 489.811
Source: 1997 AACS.

R 489.812
Source: 1997 AACS.

CREDIT UNIONS

R 490.1 Rescinded.
History: 1954 ACS 78, Eff. Jan. 4, 1974; 1979 AC; 1979 ACS 7, Eff. July 22, 1981; 1987 MR 7, Eff. July 28, 1987; 1995 MR 12, Eff. Jan. 3, 1996; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.2 Rescinded.
History: 1987 MR 7, Eff. July 28, 1987; 1995 MR 12, Eff. Jan. 3, 1996; 2005 MR 2, Eff. Feb. 10, 2005; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.4 Rescinded.
History: 1995 MR 12, Eff. Jan. 3, 1996; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.5 Rescinded.
History: 1954 ACS 78, Eff. Jan. 4, 1974; 1979 AC; 1979 ACS 1, Eff. Feb. 23, 1980; 1987 MR 7, Eff. July 28, 1987; 1995

MR 12, Eff. Jan. 3, 1996;rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.6 Rescinded.
History: 1979 ACS 1, Eff. Feb. 23, 1980; 1987 MR 7, Eff. July 28, 1987; 1995 MR 12, Eff. Jan. 3, 1996; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.9 Rescinded.
History: 1979 ACS 1, Eff. Feb. 23, 1980; 1995 MR 12, Eff. Jan. 3, 1996.

R 490.10 Rescinded.
History: 1979 ACS 1, Eff. Feb. 23, 1980; 1987 MR 7, Eff. July 28, 1987; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.11
Source: 1997 AACS.

R 490.11a Rescinded.
History: 1954 ACS 78, Eff. Jan. 4, 1974; 1979 AC; rescinded 1979 ACS 1, Eff. Feb. 23, 1980.

R 490.12 Rescinded.
History: 1987 MR 7, Eff. July 28, 1987; 1995 MR 12, Eff. Jan. 3, 1996; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.15
Source: 1997 AACS.

R 490.15a Rescinded.
History: 1987 MR 7, Eff. July 28, 1987; 1995 MR 12, Eff. Jan. 3, 1996; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.16 Rescinded.
History: 1987 MR 7, Eff. July 28, 1987; 1995 MR 12, Eff. Jan. 3, 1996; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.17 Rescinded.
History: 1987 MR 7, Eff. July 28, 1987; 1995 MR 12, Eff. Jan. 3, 1996; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.21
Source: 1997 AACS.

R 490.22
Source: 1997 AACS.

R 490.23
Source: 1997 AACS.

R 490.25
Source: 1997 AACS.

R 490.31
Source: 1997 AACS.

R 490.41 Rescinded.
History: 1954 ACS 78, Eff. Jan. 4, 1974; 1979 AC; rescinded 1987 MR 7, Eff. July 28, 1987; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.51 Rescinded.
History: 1954 ACS 78, Eff. Jan. 4, 1974; 1979 AC; 1995 MR 12, Eff. Jan. 3, 1996; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.52 Rescinded.
History: 1954 ACS 78, Eff. Jan. 4, 1974; 1979 AC; 1987 MR 7, Eff. July 28, 1987; 1995 MR 12, Eff. Jan. 3, 1996; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.81 Rescinded.
History: 1954 ACS 78, Eff. Jan. 4, 1974; 1979 AC; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.82 Rescinded.
History: 1954 ACS 78, Eff. Jan. 4, 1974; 1979 AC; 1979 ACS 1, Eff. Feb. 23, 1980; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.94 Rescinded.
History: 1979 ACS 7, Eff. July 22, 1981; 1995 MR 12, Eff. Jan. 3, 1996; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.95 Rescinded.
History: 1979 ACS 7, Eff. July 22, 1981; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.96 Rescinded.
History: 1979 ACS 7, Eff. July 22, 1981; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.97 Rescinded.
History: 1979 ACS 7, Eff. July 22, 1981; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.98 Rescinded.
History: 1979 ACS 7, Eff. July 22, 1981; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.99 Rescinded.
History: 1979 ACS 7, Eff. July 22, 1981; rescinded 2005 MR 2, Eff. Feb. 10, 2005.

R 490.101
Source: 1997 AACS.

R 490.102
Source: 1997 AACS.

R 490.103
Source: 1997 AACS.

R 490.104
Source: 1997 AACS.

R 490.105
Source: 1997 AACS.

R 490.111 Definitions.
Rule 1. (1) As used in these rules:
(a) "Act" means 2003 PA 215, MCL 490.101 to 490.601, and any amendments thereto.
(b) "Delinquent loan" means a loan on which the aggregate of payments made is less than the aggregate of principal and interest due under the terms of the loan.
(c) "Obligation" means a loan or a group of loans or an installment contract or a group of installment contracts on which the interest is computed on the basis of unpaid balances.
(d) "Months delinquent" means the number of whole months that have elapsed since a payment or partial payment has become due and remains unpaid. All payments or partial payments made shall apply successively to the first occurring payment that has become due and remains unpaid. The original terms of the promissory note or extension agreement, including loans in bankruptcy or judgment proceedings, are to be used for the purpose of calculating months delinquent.
(2) Terms defined in the act have the same meanings when used in these rules.
History: 2005 MR 2, Eff. Feb 10, 2005.

R 490.112 Corporate credit union; issuance of different classes of shares; priorities upon liquidation; investment in interest rate risk management instruments.
Rule 2. (1) A corporate credit union may issue different classes of shares that have different priorities upon liquidation,

provided the commissioner approves before issue the characteristics of the subordinated shares. Shares subordinated to insured shares and the deposit insurer may be considered a form of capital.
(2) A corporate credit union may, with prior approval of the board of directors and consistent with safe and sound business practices, invest in interest rate risk management instruments for the sole purpose of managing interest rate risk.
History: 2005 MR 2, Eff. Feb 10, 2005.

R 490.113 Credit committee or board of directors lending activity; recording requirements.
Rule 3. The credit committee shall maintain the minutes of all actions taken by the committee with regard to lending activity. If there is no credit committee, the board of directors shall maintain the minutes of all actions taken by the board with regard to lending activity. The minutes shall contain, at a minimum, all of the following items of business dealing with lending activity:
(a) The names of the credit committee or board members in attendance while the credit committee or board is dealing with lending activity.
(b) Loans and lines of credit approved or rejected, including, at a minimum, all of the following information:
(i) The member's name and account number.
(ii) The amount of the proposed loan.
(iii) Whether the proposed loan is secured or unsecured.
(iv) The action taken on the proposed loan.
(c) A report of actions taken by each loan officer on loan requests since the last meeting of the credit committee or, if there is no credit committee, the board of directors.
(d) Extension agreements approved or denied.
(e) Releases of security.
History: 2005 MR 2, Eff. Feb 10, 2005.

R 490.114 Accounting requirements for investments in mutual funds.
Rule 4. A credit union shall record each investment in shares or certificates of an open-end management investment company (mutual fund) at market value, determined at the end of each month.
History: 2005 MR 2, Eff. Feb 10, 2005.

R 490.115 Overdrafts.
Rule 5. A credit union that issues a check or draft on a financial institution in excess of the balance of its demand deposit account in that institution then shown on the books of the credit union shall be considered to be operating in an unsafe and unsound manner unless all of the following conditions are satisfied:
(a) The excess is not more than the unused portion of the current line-of-credit agreements between the credit union and the institution.
(b) The line-of-credit agreement expressly provides that it will apply to cover overdrafts by the credit union.
(c) The board of directors of the credit union has approved the line-of-credit agreement.
History: 2005 MR 2, Eff. Feb 10, 2005.

R 490.116 Delinquent loans.
Rule 6. (1) A credit union shall maintain a monthly delinquent loan report reflecting all loans that are at least 1 month delinquent. The report shall contain, at a minimum, all of the following information with respect to the borrower:
(a) Name.
(b) Account number.
(c) Loan balance.
(d) Number of months delinquent.
(e) Any other information determined necessary by the board of directors to determine the condition of the loan.
(2) The application of proceeds from a liquidation of collateral to a delinquent loan by a credit union shall reduce the balance due, but not the months delinquent, of that loan.
History: 2005 MR 2, Eff. Feb 10, 2005.

R 490.117 Minimum required allowance for loan and lease loss.
Rule 7. (1) A credit union shall maintain an allowance for loan and lease loss account at an amount at least equal to the credit union's reasonably foreseeable loan and lease losses, which shall be calculated pursuant to all of the following provisions:
(a) Management shall make a realistic appraisal of the collectability of delinquent loans and leases, known bankruptcies, judgment accounts, and other loans and leases for which collectability is questionable. The resulting estimated loss

represents the appraisal component of the allowance for loan and lease loss account. The total dollar amount of these loans and leases is subtracted from the total loan and lease amount before calculation of the experience component of the allowance for loan and lease loss account.
(b) The experience component is calculated as follows: The average of net loan and lease losses for the previous 5 years shall be calculated. This "experience" ratio shall be applied to the estimated total loan and lease balance to calculate the estimated loss in the remaining loan and lease portfolio. The average net loan and lease loss ratio shall be updated at each year end.
(c) The amount calculated that is based on the experience component shall be added to the estimated loss calculated that is based on the appraisal component to calculate the minimum amount the credit union shall maintain in the allowance for loan and lease loss account.
(2) Any deviation in the allowance for loan and lease loss calculated under subrule (1) of this rule shall be in compliance with generally accepted accounting principles and supported in writing by the certified public accountant or other professionally qualified individual who performed the most recent audit of the credit union.
(3) The credit union shall maintain documentation to support the balance in the allowance for loan and lease loss account as determined in subrules (1) or (2) of this rule. The credit union shall evaluate the adequacy of the allowance for loan and lease loss account at least quarterly.
(4) No loan may be charged to the allowance for loan and lease loss account without approval by the board of directors. The board minutes shall record the name, account number, and amount of each loan charged to the allowance for loan and lease loss account pursuant to section 386(2) of the act, MCL 490.386(2).
History: 2005 MR 2, Eff. Feb 10, 2005.

R 490.118 Access to records.
Rule 8. A credit union may not purchase or receive recordkeeping services from an outside party unless both the credit union and the outside party, including any subcontractor, furnish the commissioner with an assurance in writing that the performance of these services will be subject to examination and regulation to the same extent as if the services were performed by the credit union on its own premises.
History: 2005 MR 2, Eff. Feb 10, 2005.

SAVINGS AND LOAN ASSOCIATIONS

R 491.101
Source: 1981 AACS.

R 491.110
Source: 1981 AACS.

R 491.115
Source: 1981 AACS.

R 491.120
Source: 1981 AACS.

R 491.125
Source: 1981 AACS.

R 491.130
Source: 1981 AACS.

R 491.135
Source: 1981 AACS.

R 491.140
Source: 1981 AACS.

R 491.145
Source: 1981 AACS.

R 491.150
Source: 1981 AACS.

R 491.155
Source: 1981 AACS.

R 491.160
Source: 1981 AACS.

R 491.165
Source: 1981 AACS.

R 491.170
Source: 1981 AACS.

R 491.175
Source: 1981 AACS.

R 491.180
Source: 1981 AACS.

R 491.185
Source: 1981 AACS.

R 491.190
Source: 1981 AACS.

R 491.195
Source: 1981 AACS.

R 491.197
Source: 1981 AACS.

REGULATORY LOAN LICENSEES

R 493.1
Source: 1981 AACS.

R 493.5
Source: 1983 AACS.

R 493.10
Source: 1983 AACS.

R 493.11
Source: 1983 AACS.

R 493.12
Source: 1983 AACS.

R 493.13
Source: 1983 AACS.

R 493.14
Source: 1983 AACS.

R 493.15
Source: 1983 AACS.

R 493.16

Source: 1983 AACS.

R 493.20
Source: 1997 AACS.

R 493.95
Source: 1981 AACS.

SECONDARY MORTGAGE LICENSEES

R 493.101
Source: 1998-2000 AACS.

R 493.102
Source: 1998-2000 AACS.

R 493.110
Source: 1998-2000 AACS.

R 493.111
Source: 1998-2000 AACS.

R 493.112
Source: 1998-2000 AACS.

R 493.113
Source: 1998-2000 AACS.

R 493.114
Source: 1998-2000 AACS.

R 493.120
Source: 1998-2000 AACS.